Cigna Health and Life Insurance Company ("Cigna")
Cigna Connect Flex Bronze 7000 Rx Copay Plan

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

The following is the Policy benefit schedule, including medical, prescription drug and pediatric vision benefits. The Policy sets forth, in more detail, the rights and obligations of all Insured Persons and Cigna. It is, therefore, important that all Insured Persons **READ THE ENTIRE POLICY CAREFULLY!**

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

Remember, services from Non-Participating (Out-of-Network) Providers are not covered except for initial care to treat and Stabilize an Emergency Medical Condition. For additional details see the "Member Payment Responsibility" section of Your Policy.

MEDICAL BENEFIT SCHEDULE

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived**	**PARTICIPATING PROVIDER** **(Based on the Negotiated Rate) for Covered Expenses** **YOU PAY:**
Medical Benefits	
Deductible Individual Family	 $7,000 $14,000
Out-of-Pocket Maximum Individual Family	 $8,550 $17,100
Coinsurance	40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Prior Authorization Program **Prior Authorization – Inpatient Services**	**Your Participating Provider must obtain approval** for inpatient admissions. Failure to do so may result in a penalty or denial of payment for services provided.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more detailed information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "Coverage" then select "Medical".	**Your Participating Provider must obtain approval** for selected outpatient procedures and services. Failure to do so may result in a penalty or denial of payment for services provided.
All Preventive Well Care Services Please refer to "Benefits/Coverage (What is Covered)" section of this Policy for additional details	0%, Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for an Insured Person through the end of the month in which the Insured Person turns 19 years of age. **Please be aware that the Pediatric Vision network is different from the network for your medical benefits**	
Comprehensive Eye Exam Limited to one exam per year	0%, Deductible waived
Eyeglasses for Children Limited to one pair per two years	
Pediatric Frames	0% per pair, Deductible waived
Single Vision Lenses	0% per pair, Deductible waived
Lined Bifocal Lenses	0% per pair, Deductible waived
Lined Trifocal or Standard Progressive Lenses	0% per pair, Deductible waived
Lenticular Lenses	0% per pair, Deductible waived
Contact Lenses for Children Limited to one pair or supply per two years	
Elective	0% per pair, Deductible waived
Therapeutic	0% per pair, Deductible waived
Low Vision Services Biannual limits apply	0%, Deductible waived
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit.	

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Physician Services	
Office Visit or House Call	
Primary Care Physician (PCP)	$50 Copayment per office visit, Deductible waived
Specialist Physician (including consultant and second opinion services)	40%
Other Physician Services	
Surgery in Physician's office	40%
Outpatient Professional Fees (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	40%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	40%
In-hospital visits	40%
Allergy testing and treatment/injections	40%
Virtual Care	
Dedicated Virtual Care Medical Physician Service for minor acute medical conditions	$0 Copayment per office visit, Deductible waived
Virtual Care Service from Participating Physicians other than Dedicated Virtual Care Physicians. (This benefit excludes any services that are delivered via telephone only)	Same benefit as when service provided in person
Note: Any Prescriptions issued during a virtual visit is subject to all Prescription Drug benefits, limitations and exclusions.	
Hospital Services	
Inpatient Hospital Services	
Facility Charges	40%
Professional Charges	40%
Emergency Admissions	
Facility Charges Professional Charges	Refer to the Emergency Services Benefit Schedule for benefits on specific services.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Inpatient Treatment in a Multidisciplinary Rehabilitation Program Maximum of 60 days per condition per Calendar Year	40%
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived
Male Sterilization	Copayment or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery)/Complications of Pregnancy **Initial visit to confirm pregnancy** and subsequent prenatal visits billed separately from the "global" fee **Prenatal services, Postnatal and Delivery** billed as "global" fee **Hospital Delivery** **Prenatal testing or treatment** billed separately from "global" fee **Postnatal visit or treatment** billed separately from "global" fee	 PCP or Specialist Office Visit benefit applies 40% Inpatient Hospital Services benefit applies Copayment or Coinsurance applies for specific service provided Copayment or Coinsurance applies for specific service provided
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	40%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans and Nuclear Medicine) Facility and interpretation charges	40%
All Other Laboratory and Radiology Services Facility and interpretation charges **Physician's Office** **Free-standing/independent lab or x-ray facility** **Outpatient hospital lab or x-ray**	 40% 40% 40%
Rehabilitative Services **Physical, Occupational, Speech Therapy** Maximum of 20 visits for each therapy per Insured Person, per Calendar Year **Note: Maximum does not apply to services for treatment of Autism Spectrum Disorders**	40%

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Autism Spectrum Disorders **Diagnosis of Autism Spectrum Disorder** **Office Visit** **Diagnostic Testing** **Treatment of Autism Spectrum Disorder** (see "**Benefits/Coverage (What is Covered)**" section for specific information about what services are covered)	PCP or Specialist Office Visit benefit applies 40% Copayment or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 100 days per Insured Person, per Calendar Year for Skilled Nursing Facility.	40%
Home Health Care Services Maximum of 28 hours per week	40%
Durable Medical Equipment	40%
Orthotic Devices	40%
Breast Feeding Equipment and Supplies Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	0%, Deductible waived
External Prosthetic Devices	20%, Deductible waived
Orthopedic Appliances	40%
Hospice **Routine Home Care** **Inpatient** **Outpatient**	 40% 40% 40%
Dialysis **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 40%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Mental Health Disorder (including Behavioral Mental Health Disorders)	
Inpatient (includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	Specialist Office Visit benefit applies
Telehealth/Virtual Therapy	Same benefit as when service provided in person
All other outpatient services	40%
Substance Use Disorder	
Inpatient Rehabilitation (includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Inpatient Detoxification	Inpatient Hospital Services benefit applies
Outpatient (includes individual, group, intensive outpatient and partial hospitalization)	
Office visit	Specialist Office Visit benefit applies
All other outpatient services	40%
Organ and Tissue Transplants	
Cigna LifeSOURCE Transplant Network® Facility	0%
Travel Benefit, (Only available through Cigna LifeSOURCE Transplant Network® Facility)	
Travel benefit Lifetime maximum payment of $10,000	Inpatient Hospital Services benefit applies
Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services	Not Covered
Participating Facility NOT specifically contracted to perform Transplant Services	

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived	PARTICIPATING PROVIDER (Based on the Negotiated Rate) for Covered Expenses YOU PAY:
Ventricular Assist Device Services **Cigna LifeSOURCE Transplant Network® Facility** **Non-LifeSOURCE Participating Facility specifically contracted to perform Ventricular Assist Device Services** **Participating Facility NOT specifically contracted to perform Ventricular Assist Device Services**	0% Inpatient Hospital Services benefit applies Not Covered
Infertility (see "**Benefits/Coverage (What is Covered)**" section for specific information about what services are covered and benefit limits which may apply) Inpatient Outpatient	Inpatient Hospital Services benefit applies 40%
Bariatric Surgery (Subject to medical necessity) Inpatient Outpatient	Inpatient Hospital Services benefit applies 40%
Infusion and Injectable Medications and related services or supplies administered by a medical professional in an office or outpatient facility	40%
Specified Diabetic Services and Supplies	0%, Deductible Waived

EMERGENCY SERVICES BENEFIT SCHEDULE

BENEFIT INFORMATION Emergency Services This Policy covers Emergency Services from Participating and Non-Participating Providers; Covered Services are subject to applicable Deductible unless specifically waived.	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
Hospital Emergency Room		
Emergency Medical Condition	$750 Copayment	In-Network Cost Share applies
Non-Emergency Medical Condition	Not Covered (You pay 100% of charges)	Not Covered (You pay 100% of charges)
Urgent Care Center Facility		
Emergency Medical Condition	$60 Copayment, Deductible waived	In-Network Cost Share applies
Non-Emergency Medical Condition	$60 Copayment, Deductible waived	Not Covered (You pay 100% of charges)
Ambulance Services **Note:** coverage for Medically Necessary transport: to the nearest facility capable of handling the Emergency Medical Condition		
Emergency Transport	40%	40%
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges (Emergency Services from a Non-Participating Provider are covered at the In-Network benefit level until the patient is transferrable to a Participating facility. Non-Participating facility benefits are not covered once the patient can be transferred, whether or not the transfer takes place.)	40%	In-Network Cost Share applies until transferable to an In-Network Hospital, if not transferred then Not Covered (You pay 100% of Charges)
Professional Services	40%	In-Network Cost Share applies until transferable to an In-Network Hospital, if not transferred then Not Covered (You pay 100% of Charges)

PRESCRIPTION DRUG BENEFIT SCHEDULE

BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	EXPRESS SCRIPTS PHARMACY, Cigna's HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN BELOW ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		

Note:
You can obtain a 30-day supply of any covered Prescription Drug or Related Supply at any Participating Retail Pharmacy.

You can obtain up to a 90-day supply of any covered Prescription Drug or Related Supply at either a 90 Day Retail Pharmacy or through the Express Scripts Pharmacy, Cigna's 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 indicated in this benefit schedule

For all insulin drugs covered by this Policy your cost share amount will be capped so that the amount you are required to pay for a covered prescription insulin drug will not exceed $100 dollars per 30 day supply. Deductible will be waived.

Prescription Drug Deductible	The Individual and Family Deductible shown on the first page of the benefit schedule applies to Prescription Drugs and Related Supplies	
	Cigna Retail Pharmacy Drug Program YOU PAY PER PRESCRIPTION OR REFILL:	**Express Scripts Pharmacy, Cigna's home delivery Pharmacy** 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.	$10 Copayment, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply	$30 Copayment, Deductible waived per Prescription or refill 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.	$35 Copayment, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply	$105 Copayment, Deductible waived per Prescription or refill Up to a 90 day maximum supply

BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN BELOW ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	EXPRESS SCRIPTS PHARMACY, Cigna's HOME DELIVERY PHARMACY YOU PAY
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	$250 Copayment, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply	$750 Copayment, Deductible waived 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.	$600 Copayment, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply	$1,800 Copayment, Deductible waived per Prescription or refill Up to a 90 day maximum supply
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	$675 Copayment, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 30 day supply – at a 90 Day Retail Pharmacy	$600 Copayment, Deductible waived 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 are Generic or Brand name with no Generic alternative available; and • smoking cessation products limited to a maximum of 2 90-day treatment regimens	0%, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy	0%, Deductible waived per Prescription or refill Up to a 90 day maximum supply

TITLE PAGE (COVER PAGE)

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

Cigna Health and Life Insurance Company ("Cigna")
Cigna Connect Flex Bronze 7000 Rx Copay Plan

If You Wish To Cancel Or If You Have Questions

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

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

Include Your Cigna identification number with any correspondence. This number can be found on Your Cigna identification card. You can also call the number on the back of Your ID card for information.

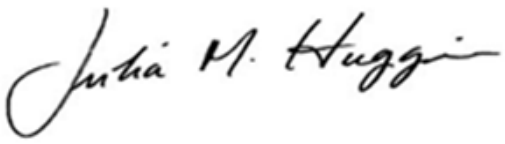
THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health and Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application. If You know of any misstatement in Your application You should advise the Company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

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

Guaranteed Renewable

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

Signed for Cigna by:



Julia M. Huggins, President

Anna Krishtul, Corporate Secretary

CONTACT US

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

You can also contact Cigna at:

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

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

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

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

You do not need Prior Authorization from the plan or from any other person (including your 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 may require or allow 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 Physicians, 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.

Table of Contents

ELIGIBILITY

Eligibility Requirements

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

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- You are a resident of the state of CO; and
- You live in the Enrollment Area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges; and
- You do not reside in an Institution; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.

The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

Other Insured Persons may include the following Family Member(s):

- Your lawful spouse, including a partner in a civil union, who lives in the Enrollment Area.
- Your children who live in the Enrollment Area and have not yet reached age 26.
- Your stepchildren who live in the Enrollment Area and have not yet reached age 26.
- Your own, or Your spouse's children, regardless of age, enrolled prior to age 26, who live in the Enrollment Area and are dependent upon the Insured Person for support and maintenance due to a medically certified, continuing intellectual or physical disability. Cigna may require written proof of such disability and dependency within 31 days after the child's 26th birthday.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as a Family Member by applying for his or her enrollment as a dependent within 60 days of the date of birth, and pay any additional Premium. 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 Family Member by applying for his or her enrollment as a dependent within 60 days of the date of adoption, and pay any additional Premium. 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, initiation of a suit of adoption or after the date the child is placed with you for adoption, and paying any additional premium.
- A child who is placed with you for foster care, is automatically covered for 31 days from the date of placement with you for foster care. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of placement with you for foster care, and pay any additional Premium. Coverage for a foster child enrolled within 60 days of being placed with you for foster care will be retroactive to the date of the child's initial placement with you in foster care and paying any additional premium.
- If a court has ordered a Policyholder 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 Family 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 enrolled as a Family Member under this Policy who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only Emergency Services for Emergency Medical Conditions.

When Can I Apply?

Application to Enroll or Change Coverage

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

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

Annual Open Enrollment Period

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

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

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

Colorado Annual Market Stabilization Special Enrollment Period

The annual market stabilization special enrollment period begins each year on December 16th and extends through January 15th. Individual health benefit plans purchased during the annual market stabilization special enrollment period are to be effective no later than February 1st. This is to ensure that individuals have sufficient opportunity to enroll in a health benefit plan after the end of the annual open enrollment period and to ensure the continued health and stability of the Colorado health insurance market. The special enrollment period eligibility verification and prior coverage requirements do not apply to the annual market stabilization special enrollment period.

Special Enrollment Periods

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

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

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

Triggering events for a special enrollment period are:

- An individual or his or her dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage;
- An individual or his or her dependent loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage, or
- When a Marketplace enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the Marketplace enrollee, or his or her dependent dies.
- An individual or his or her dependent losing medically needy coverage as described under Section 1902(a)(10)(C) of the Social Security Act may apply, once during a Calendar Year, for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage;
- Gaining a dependent or becoming a dependent through marriage (NOTE: special enrollment for marriage only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaska Native), civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;
- An individual's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Marketplace;
- Demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual;
- A qualified individual who becomes:
    1. newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;
    2. Has a dependent enrolled in the same qualified health plan who is determined newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;
    3. Becomes newly eligible, or his or her dependent becomes newly eligible, for enrollment in a QHP through the Exchange because they have been released from incarceration;
    4. Was previously ineligible for federal premium tax credit solely because of a household income below one hundred percent (100%) of the Federal Poverty Level and who, during the same timeframe, was ineligible for Medicaid because he or she were living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the qualified individual becoming newly eligible for advance payments of the federal premium tax credit; or
    5. Is enrolled, or has a dependent enrolled, in an eligible employer-sponsored plan and is determined newly eligible for the federal advance payment tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of his or her employer discontinuing or changing coverage within the next 60 days, provided the enrollee is able to terminate his or her existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage.
- Gaining access to other creditable coverage as a result of a permanent change in residence;
- A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);
- An individual becoming ineligible under the Colorado Medical Assistance Act;
- An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status;
- An Indian or an Alaska Native, as defined by Section 4 of the Indian Health Care Improvement Act or their dependent on the same application, may enroll in a qualified health plan or change from one qualified health plan to another one time per month.;
- An individual or his or her dependent currently enrolled in an individual or group non-Calendar Year health benefit plan may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the effective date of the loss of coverage, which is the last day of the plan or policy year;
- An individual or his or her dependent enrolling in a health benefit plan may apply for enrollment in a new health benefit plan during the market stabilization special enrollment period;

- An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR § 1.36B-2T, including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;
- An individual or his or her dependent who applies for coverage during the annual open enrollment period or due to triggering event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than 60 days after the triggering or qualifying event, or applies for coverage through the State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended;
- An individual, or his or her dependent, who has purchased an off-Marketplace plan, adequately demonstrates to the Commissioner that a material error related to plan benefits, Service Area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP;
- An individual, or his or her dependent, who has purchased an on-Marketplace plan, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP;
- An individual, or his or her dependent, adequately demonstrates to the Exchange, in accordance with federal guidelines, that the individual meets other exceptional circumstances as the Exchange may provide;
- An individual who has purchased a short-term limited duration health insurance policy experiences an involuntary loss of coverage at the end of the term of his/her policy if there is no ability to purchase another short-term policy due to the short-term policy carrier ceasing its sales of all short-term policies in Colorado on or after April 1, 2019. Such individuals may apply for enrollment in a new individual health benefit plan in accordance with what is noted under (1) and (2) above, or during the sixty (60) calendar days after 9/1/2019.
- An individual, or his or her dependent, who has purchased an off-Marketplace plan who experiences a decrease in household income; is newly determined eligible for APTC; and had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change.
- An eligible individual newly gains access to an employer sponsored individual coverage health reimbursement account (ICHRA); or
- An eligible individual newly gains access to a qualified small employer health reimbursement arrangement (QSEHRA)

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. When a non-qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the 30 calendar days prior to the effective date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. When a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the 60 calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs to avoid a gap in coverage. A "qualified individual", means an individual who has been determined eligible to enroll through the Marketplace in a Qualified Health Plan (QHP) in the individual market.

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, the effective date will be the date of the event or the first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the Policyholder; or
- In the case of marriage, civil union, or in the case where a qualified individual loses minimum essential coverage, coverage is effective the first day of the following month;
- In the case of an involuntary loss of existing creditable coverage, coverage shall become effective either: on the first day of the month following the triggering event if plan selection is made on or before the day of the triggering

event; or in accordance with the effective dates outlined in regulation, or at the option of the Marketplace, on the first day of the month following plan selection when plan selection is made after a triggering event.

- In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either: on the date the court order is effective; or at the election of the primary individual policyholder regarding the first and 15th of the month or 16th and last day of the month as noted below.

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 no later than 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 no later than the first day of the second following month.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

About This Policy

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

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

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

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(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 FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER (S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 60 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEED TOTAL PREMIUMS PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE.

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

THIS IS AN EXCLUSIVE PROVIDER POLICY

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

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

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

Choosing a Primary Care Physician

A Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, when you enroll as an Insured Person, you will be asked to select a Primary Care Physician ("PCP"). Your PCP will provide your regular medical care and assist in coordinating your care. You may select your PCP by calling the customer service phone number on your ID card or by visiting Our website at www.mycigna.com. The Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of Your Family Member(s). You have the right to designate any Primary Care Physician who participates in Our network for this plan and is available to accept You or Your Family Members.

If You Need A Specialist

Your PCP is important to the coordination of your care. While this Policy does not require referrals to visit specialists, if you need specialty care you are encouraged to work with your PCP, who can coordinate your care and assist you in selecting a specialist appropriate for your care.

The referral system can be used to keep your PCP involved in and apprised of all of your health care needs. If you receive Covered Services from a specialist in the Policy's network without a referral, you will not be subject to a penalty, and the claims for those Covered Services will be processed according to the applicable in-network level of benefits.

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 plan Year that you will be allowed to change your PCP. You may request a change from one Primary Care Physician to another by going to mycigna.com, clicking on "Manage My Health Team", click "Additional info on PCP selection", and follow the directions displayed or by contacting Us at the Customer Service number on your ID card.

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 Physician Leaves the Network

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

Continuity of Care

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

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

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

- Successful transition of your care to a Participating Provider, or

- Completion of your treatment; or
- The next Annual Open Enrollment Period; or
- The length of time approved for continuity of care ends.

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 are enrolled as an Insured Person, 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 Provider and/or Participating Hospital if Cigna, 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, refuse to permit Us to coordinate your care, or refuse to be transferred to the care of a Participating Provider 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.

Note Regarding Health Savings Accounts (HSAs)

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

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

Prior Authorization Program

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

Prior Authorization for Inpatient Services

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facility MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Prior Authorization can be obtained by You, your Family Member(s) or the Provider by calling the number on the back of your ID card.

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

- call Cigna at the number on the back of your ID card, or
- check www.mycigna.com, under "Coverage" then select "Medical"

Please note that emergency admissions will be reviewed post admission.

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

Prior Authorization for Outpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check www.mycigna.com, under “Coverage” then select “Medical”

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

Retrospective Review

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

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

Prior 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, except if the Prescription Drug is an HIV infection prevention drug. 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 an Insured Person to follow certain steps before covering some Prescription Drugs and Related Supplies, including, without limitation, some higher-cost and Specialty Medications. If a Prescription Drug or Related Supply is subject to a Step Therapy requirement, then you must to try one or more similar Prescription Drugs and Related Supplies before the Policy will cover the requested Prescription Drug or Related Supply, except if the Prescription Drug is an HIV infection prevention drug or a covered Prescription Drug approved by the U.S. Food and Drug Administration or other recognized body for the treatment of stage four advanced metastatic cancer. 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 Prescription Drug or Related Supply not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt.

If the request is approved, your Physician will receive confirmation. The Authorization/Exception will be processed in Cigna's pharmacy claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the Authorization will be granted until you no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When Your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

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

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

If you, a person acting on your behalf or the prescribing Physician or other prescriber disagree with a coverage decision, you, a person acting on your behalf or the prescribing Physician or other prescriber may appeal that decision in accordance with the provisions of this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled "When You Have a 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.

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

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

NOTE REGARDING PRIOR AUTHORIZATION OF INPATIENT SERVICES, OUTPATIENT SERVICES AND PRESCRIPTION DRUGS

Some services or therapies may require you to use particular Providers approved by Cigna for the particular service or therapy, and will not be covered if you receive them from any other Provider regardless of participation status.

Coverage of New Drugs

All new Food and Drug Administration (FDA)-approved Prescription Drugs or Related Supplies (or new FDA-approved indications) are designated as Non-Prescription Drug List Prescription Drugs or Related Supplies until the Cigna Business Decision Team makes a placement decision on the new Prescription Drug or Related Supply (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 Prescription Drugs or Related Supplies (or new FDA approved indications) within 90 days of its release to the market. The Business Decision Team must 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.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the benefit schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses.

Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person received the service or supply.

Deductible

The Deductible is stated in the benefit schedule. The Deductible is the amount of Covered Expenses you must pay for **any** Covered Services (except as specifically stated otherwise in the benefit schedule) incurred from Participating Providers each Year before any benefits are available. There are two ways an Insured Person can meet his or her Deductible:

- When an Insured Person meets his or her Individual Deductible, that Insured Person's benefits will be paid accordingly, whether any applicable Family Deductible is satisfied or not.

- If one or more Family Members are enrolled for coverage under this Policy, the Family Deductible will apply. Each Insured Person can contribute up to the individual Deductible amount toward the Family Deductible. Once this Family Deductible is satisfied, no further Individual or Family Deductible is required for the remainder of that Year.

Out-of-Pocket Maximum

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

- The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for 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 Policy.
- The Family Out-of-Pocket Maximum applies if You have a family plan and You and one or more of your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Covered Expenses, including Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services, paid by each Family Member for Covered Expenses during a Year. If You cover other Family Member(s), each Insured Person's Covered Services accumulate toward the Family Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, the Family Members will no longer have to pay any Deductible, Coinsurance or Copayments for Covered Expenses incurred during the remainder of that Year. The amounts of the Individual and the Family Out-of-Pocket Maximum are described in the benefit schedule section of this Policy.

Penalties

A penalty is an amount of Covered Expenses that is:

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

The following services require Prior Authorization. Penalties will be assessed against your Provider if your Provider fails to obtain Prior Authorization.:

- Inpatient Hospital admissions and all other facility admissions,
- Free Standing Outpatient Surgical Facility Services,
- Certain outpatient surgeries and diagnostic procedures.

Penalties are applied before any benefits are available.

BENEFITS/COVERAGE (WHAT IS COVERED)

Medical Benefits (listed in alphabetical order)

Please refer to the benefit schedule for additional benefit provisions which may apply to the information below.

To be eligible for benefits under this Policy, the Provider must be appropriately licensed according to state and local laws and accredited to provide services within the scope of the Provider's license and accreditation.

Before this Participating Provider Policy pays for any benefits, You and Your Family Members must satisfy any Deductibles that may apply. After you satisfy the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

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

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

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

If you are inpatient in a Hospital or Other Health Care Facility, on the day your coverage begins, We will pay benefits for Covered Services that you receive on or after your first day of coverage related to that inpatient stay as long as you receive Covered Services in accordance with the terms of this Policy. These benefits are subject to any prior carrier's obligations under state law or contract.

Ambulance Services

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

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

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

Anesthesia for Dental Procedures

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

Autism Spectrum Disorders

This Policy provides benefits for Covered Expenses for Insured Persons for Charges made for:

- diagnosis of Autism Spectrum Disorders; and
- treatment of 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) a Physician licensed to practice medicine in all its branches 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 in all its branches.

Except for inpatient services, upon request from Cigna and not more than once every 12 months, a Provider 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 and is resulting in improved clinical status. 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.

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- 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.
- 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.

Bariatric Surgery

Coverage is provided for Medically Necessary bariatric surgery, subject to all Plan referral and Authorization requirements.

Cardiac and Pulmonary Rehabilitation Services

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

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

Cleft Lip-Cleft Palate

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

Clinical Trials

Benefits are payable for all routine patient care costs related to an approved clinical trial provided by a Participating Provider, including phases I through IV, for cancer, disabling, progressive or life-threatening conditions for an Insured who meets the following requirements:

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

(2) Either—

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

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;

   i. An institute or center of the National Institutes of Health,

   ii. The Food and Drug Administration,

   iii. The Department of Veterans' Affairs,

   iv. The Department of Defense,

   v. The Department of Energy,

   vi. The Centers for Disease Control and Prevention,

   vii. The Agency for Health Care Research and Quality,

   viii. The Centers for Medicare & Medicaid Services,

   ix. cooperative group or center of any of the entities described in clauses (i) through (vi) or the Department of Defense or the Department of Veterans Affairs, or

   x. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

- Services typically provided absent a clinical trial.
- Services required solely for the provision of the investigational drug, item, device or service.
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service.
- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service.

- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs do not include—

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. Costs for the management of research relating to the clinical trial or study;
4. Any portion of the clinical trial or study that is paid for by a government or a bio-technical, pharmaceutical, or medical industry;
5. Coverage for any drug or device that is paid for by the manufacturer, distributor, or Provider of the drug or device;
6. Extraneous expenses related to participation in the clinical trial; or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.

COVID – 19

This Policy provides benefits for testing and treatment of COVID-19, as required under any applicable Federal or Colorado bulletins, laws or regulations.

Dental Care

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

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

Diabetes

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

Durable Medical Equipment

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

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

Durable medical equipment includes, but is not limited to:

- Bed related items: bed trays, over-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses;
- Bath related items: bath lifts, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, and bath mats;
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient fits (mechanical or motorized – manual hydraulic lifts are covered if patient requires two-person transfer), and auto tilt chairs;
- Fixtures to real property: ceiling lifts and wheelchair ramps;
- Car/van modifications;

- Blood/injection related items: blood pressure cuffs, nova pens and needleless injections;
- Other equipment: heat lamps, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, enuresis alarms, magnetic equipment scales (baby and adult), and stair gliders.
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Serve a medical purpose and is expected to be of no further use when medical need ends;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;
  - Not for exercise;
  - And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above requirements in order to be eligible for benefits under this Policy. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. Coverage for Durable Medical Equipment is limited to the 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 person's misuse are the person's responsibility.

Early Intervention Services

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

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

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

Early Intervention Services do NOT include:

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

The coverage will not be subject to Deductibles or Copayments.

External Prosthetic Appliances and Devices

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

External Prosthetic Appliances and Devices shall include Prostheses/Prosthetic Appliances and Devices, Orthoses and Orthotic Devices; Braces; and Splints.

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 Insured Person.

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

- Only the following non-foot Orthoses are covered, when Medically Necessary, as follows:
  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 Insured Persons 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 Insured Persons with a 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 Insured Person 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.

Foreign Country Providers

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

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

Habilitative Services

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

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

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

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

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

Hearing Services

This Policy provides benefits for Covered Expenses for hearing services as follows:

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

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

Coverage shall include the purchase of the following:

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

Coverage does NOT include:

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

Home Health Care

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

The following services are covered:

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

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

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

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

Hospice Services

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

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

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

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

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

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

Infertility Services

This Policy provides benefits for Covered Expenses incurred for the following Services, including X-ray and laboratory procedures:

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

Inpatient Services and Supplies at a Hospital or Free-Standing Outpatient Surgical Facility

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- Private duty nursing as part of inpatient hospital care, covered only if determined to be medically necessary.
- Physical, occupational and speech therapy is covered as part of inpatient hospital care if, in the judgment of a physician, significant improvement is achievable within a 2 month period.

- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Free-Standing Outpatient Surgical Facility.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Inpatient Services at Other Health Care Facilities

For any eligible condition, this Policy provides indicated benefits for Covered Expenses for inpatient services and supplies provided by an Other Health Care Facility, except private room Charges above the prevailing two-bed room rate of the facility. Physical, occupational and speech therapy is covered as part of skilled nursing care if, in the judgment of a physician, significant improvement is achievable within a 2 month period.

Payment of benefits for Other Health Care Facility services is subject to all of the following conditions:

- The Insured Person must be referred to the Other Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by an Other 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 Insured Person 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 Health Care Facility.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Mastectomy and Related Procedures

This Policy provides benefits for Covered Expenses for Hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer.

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

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

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

Medical Foods

This Policy provides benefits for Covered Expenses incurred for Medical Foods to treat inherited enzymatic disorders, caused by single gene defects involved in the metabolism of amino, organic, fatty acids and severe protein allergic conditions in newborns, including, but not limited to, the following diagnosed conditions: Phenylketonuria; maternal Phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic academia; immunoglobulin E and Nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.. "Medical Foods" means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designated and manufactured for the treatment of inherited enzymatic disorders, not including cystic fibrosis or lactose-intolerant or soy-intolerant disorders. Coverage will be the same for Medical Foods purchased in-network or out-of-network.

Medical and Surgical Supplies

The Policy includes coverage for medical and surgical supplies that are Medically Necessary, serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly, creams or lotions.

Mental Health and Substance Use Disorder Services

This Policy provides benefits for Covered Services as indicated below for inpatient and outpatient evaluation and treatment of Mental Health and Substance Use Disorders. Mental Health and Substance Use Disorder services that are not covered by this Policy are listed in the "LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)" section.

Inpatient Services

Benefits include Covered Services provided by a Hospital for the evaluation and treatment of Mental Health and/or Substance Use Disorder during an inpatient admission for acute care for conditions such as:

- a patient who presents a danger to self or others;
- a patient who is unable to function in the community;
- a patient who is critically unstable;
- a patient who requires acute care during detoxification; and
- the diagnosis, evaluation and acute treatment of addiction to alcohol and/or drugs.

Benefits also include Covered Services provided by a Mental Health or a Substance Use Disorder Residential Treatment Center for an Insured Person who is confined in a Hospital or a Mental Health or Substance Use Disorder Treatment Residential Treatment Center as a registered bed patient, upon the recommendation of a Physician. Covered Services include hospitalization and residential treatment services provided by a Hospital or a Mental Health or Substance Use Disorder Residential Treatment Facility for the evaluation and treatment of psychological and social disturbances resulting from a subacute Mental Health or Substance Use Disorder condition that prevents an Insured Person from participating in treatment within the community and/or requires rehabilitation.

Outpatient Services

Benefits include Covered Services by Participating Providers who are qualified to treat Mental Health or Substance Use Disorders, when treatment is provided on an outpatient basis for treatment of conditions such as: anxiety or depression which interfere 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 thinking; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention), outpatient testing, and assessment, and medication management when provided in conjunction with a consultation. Covered Services include:

- Treatment of mental health conditions in an individual, family, group, partial hospitalization or intensive outpatient therapy setting. Includes Telehealth/virtual therapy.
- Treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Use Disorder program. Intensive outpatient

structured therapy programs provide a combination of individual, family and/or group therapy totaling 9 or more hours in a week.

- Mental Health or Substance Use Disorder partial hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health or Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

Multidisciplinary Rehabilitation Services Facilities Services and Supplies

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

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

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Multidisciplinary Rehabilitation Facility.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Organ and Tissue Transplants 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 the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal, including 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 evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

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 call1-800-287-0539.

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. Benefits for transportation and lodging are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. The term "recipient" includes an Insured Person receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Insured Person receiving the transplant will include Charges for:

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

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

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

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

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

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

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

Orthopedic Appliances

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

Pregnancy and Maternity Care

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

All comprehensive benefits described in this Policy 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 Policy titled "Eligibility".

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

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

Preventive Care Services

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

- Routine physical exams, including: guidance and counselling regarding Substance Use Disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counselling.

- Tobacco cessation services, including screenings, intervention services, behavioral interventions and Prescription Drugs. Note: A maximum of two Smoking Cessation Attempts are covered, see the definition in the ‘Definition’ Section of this Policy.
  - Four tobacco cessation counseling sessions per attempt of at least 10 minutes each (including telephone counseling, group counseling and individual counseling);
  - Two Smoking Cessation Attempts are covered under the Prescription Drug benefit;
  - Prescription drugs smoking cessation products limited to a maximum of 2 90-day treatment regimens; including prescription medications and over-the-counter medications with a Physician’s prescription; please see the No Cost Preventive Care Drug List on myCigna.com for details.
  - Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.

  FDA approved tobacco cessation medications covered at $0:
  - bupropion hcl 150mg er tablet (generic Zyban)
  - nicotine gum (OTC)
  - nicotine lozenge (OTC)
  - nicotine patch (OTC)

  If medical necessity requested and customer is unable to use generic prescription or OTC smoking cessation products then covered at $0:
  - Chantix
  - Nicotrol Inhaler
  - Nicotrol Nasal Spray

  Note: Colorado residents 15 years and older who are ready to quit smoking can also call the Colorado QuitLine at 1-800-QUIT-NOW (1-800-784-8669).

- An annual breast cancer screening with mammography, annual Pap test annual prostate cancer screening, including a prostate –specific antigen (PSA) blood test, colorectal screening for all high risk individuals and full cost of cervical cancer vaccine.
- Influenza and pneumococcal vaccinations
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Detailed information is available at: www.healthcare.gov/coverage/preventive-care-benefits

Note: Covered Services do not include routine examinations, care, screening or immunization for travel (medications used for travel prophylaxis, except anti-malarial drugs), employment, school or sports.

Professional and Other Services

The Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Virtual Care Services
- Services of an anesthesiologist or an anesthetist;
- Consultations with clinical pharmacists
- Medical social services
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products;

Rehabilitative Therapy for Insured Persons with Congenital Defects and Birth Abnormalities

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

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

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

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

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

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

Telehealth/Telemedicine

Benefits are payable as any other medical condition for telemedicine.

Telemedicine, includes the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio and video communication. Please refer the "Definitions" section of this Policy for a complete description of the services.

Note: this benefit does not include services provided by Dedicated Virtual Care Physicians.

Temporomandibular Joint Dysfunction (TMJ) Treatment

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

Transgender Services

This Policy provides benefits for Covered Expenses incurred for treatment of gender dysphoria, gender identity disorder, procedures, surgery or treatments to change characteristics of the body to those of the opposite sex when such services are Medically Necessary or otherwise meet applicable coverage requirements.

Prescription Drug Benefits

Covered Expenses

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

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

Patient Assurance Program

Your Policy offers additional discounts for certain covered Prescription Drugs that are dispensed by a Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this Policy, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your out of pocket expenses for certain covered Prescription Drugs for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drugs included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drugs as set forth in the benefit schedule may be reduced in order for Patient Assurance Program discounts or other payments earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.

For example, certain insulin drugs covered under the Prescription Drug benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program may result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in the benefit schedule, for the insulin drugs. In addition, the covered insulin drugs eligible for Patient Assurance Program discounts may not be subject to any applicable Deductible, if any.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drugs under the Patient Assurance Program applies toward your Out-of-Pocket Maximum.

Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drugs, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drugs. Except as may be noted elsewhere in this Policy, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drugs included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drugs, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drugs included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.

What Is Covered

- Outpatient drugs and medications that federal and/or applicable State of Colorado laws restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.
- A 5-day supply, without Prior Authorization, for at least 1 of the Food and Drug Administration (FDA)-approved drugs for the treatment of opioid dependence, limited to once per 12-month period;
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Contraceptive drugs and devices approved by the FDA. Currently the Food and Drug Administration (FDA) has approved 18 different methods of contraception. All FDA approved methods of contraception are covered under this policy without cost sharing as required by federal and state law.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments will not exceed the Copayment or Coinsurance amount that would be applied to an intravenously administered or an injected cancer medication prescribed for the same purpose.
- Off-label use of cancer medication if a) the drug is recognized for the treatment of that cancer in authoritative reference compendia as identified by the secretary of the U.S. Department of Health and Human Services; and b) the treatment is for a covered condition.
- Prescription eye drops will be allowed to be refilled early if, the renewal is requested by the insured at least;
  (1) 21 days for a 30 day supply of eye drops,
  (2) 42 days for a 60 day supply of eye drops,
  (3) 63 days for a 90 day supply of eye drops,
  from the last date the prescription was filled or refilled. The original prescription should state that an additional quantity is needed.
  We will allow an additional bottle if needed by the insured for use in a day care center, school, or adult day program. The additional bottle is limited to one (1) bottle every three (3) months. The prescription eye drop benefits are subject to the same Annual Plan Deductible, Copayment or Coinsurance established for all other Prescription Drugs.
- All non-infused compound Prescriptions that contain at least one covered 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.
- Specialty Medications
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, when available for administration at a Pharmacy.

Conditions of Service

The Drug or medicine must be all of the following:

- Prescribed in writing, except for insulin, by a Physician and dispensed within one year of being prescribed, subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however, dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's Illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the Express Scripts Pharmacy, Cigna's home delivery Pharmacy.
- The drug or medicine must not be used while the Insured Person is an inpatient in any facility.
- The Prescription must not exceed the days' supply indicated in the "Limitations" section below.
- Infusion and Injectable Medications and Specialty Medications may require Prior Authorization or Step Therapy.

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, where applicable.

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

What Is Covered

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

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Eyeglass lenses – 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:
  - Scratch-coating
  - Ultra-Violet (UV) coating
  - Oversize lenses
  - Solid and gradient tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: anti-reflective coatings; photochromic (glass or plastic); polarized; Hi-Index and lens styles such as Blended Segment, Intermediate and Premium Progressive lenses.

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

- Frames – One frame for prescription lenses per two years from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered at 100%. Non-Collection Frames: Insured Person cost share up to 75% of retail.
- Elective Contact Lenses– One pair or a single purchase of a supply of contact lenses every two years in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year), including the professional services.
- Therapeutic Contact Lenses are covered every two years, 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 two years for an Insured Person 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 high-powered spectacles, magnifiers and telescopes, which can aid the Insured Person with their specific needs.

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

Cigna Vision Providers

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

LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

Excluded Services

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

- Services obtained from a Non-Participating/Out-of-Network Provider, except for treatment of an Emergency Medical Condition.
- Any amounts in excess of maximum benefit limitations of Covered Expenses stated in this Policy.
- Services not specifically listed as Covered Services in this Policy.
- Services or supplies that are not Medically Necessary.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures or Unproven Procedures.
- Services received before the Effective Date of coverage.
- Services received after coverage under this Policy ends.
- Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot, unless it occurred during a community protest; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured Person being engaged in an illegal occupation.
- Any services provided by a local, state or federal government agency, except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid or medical assistance benefits under the Colorado Medical Assistance Act, Title 25.5, Articles 4, 5, and 6, C.R.S.). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare part A, B, C or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is medically necessary and listed as covered in this Policy.
- Professional services or supplies received or purchased from Yourself or 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.
- Services of a Hospital emergency room for any condition that is not an Emergency Medical Condition as defined in this Policy.
- Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care.

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

  This exclusion does not apply to mammography.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction , except for treatment for medically necessary orthodontia for a person born with a cleft lip or cleft palate..
- Dental Implants: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants, excludes medically necessary treatment of cleft lip, cleft palate.
- Any services covered under both this medical plan and an accompanying exchange-certified pediatric dental plan and reimbursed under the dental plan will not be reimbursed under this plan.
- Hearing aids, except as specifically stated in this Policy, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), limited to the least expensive professionally adequate device. A hearing aid is any device that amplifies sound.
- Routine hearing tests except as specifically provided in this Policy under “Benefits/Coverage (What is Covered)”.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Gene Therapy including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.

- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Cosmetic surgery, therapy or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury, medically necessary surgery or congenital defect of a Newborn child, or to treat congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Nonmedical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays, except as specifically stated in this Policy. This exclusion does not apply to health education services for chronic diseases and self-care on topics such as stress management and nutrition.
- Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty and blepharoplasty, regardless of clinical indications.
- Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire
- The following services related to the evaluation or treatment of fertility and/or Infertility, sterilization reversals; donor semen and donor eggs; ovum transplants; In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
- Cryopreservation of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition
- Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices (except for treatment as a result of diabetes).
- External and internal power enhancements or power controls for prosthetic limbs and terminal devices.
- Myoelectric prostheses peripheral nerve stimulators.
- Electronic prosthetic limbs or appliances unless Medically Necessary, when a less-costly alternative is not sufficient.
- 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.
- 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.

- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, except as otherwise stated in this Policy under "Bariatric Surgery".
- Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this Policy.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Treatment that will not result in a favorable modification or prevent deterioration.
- Educational services except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- Nutritional counseling or food supplements, except as stated in this Policy.
- Exercise equipment, comfort items and other medical supplies and equipment not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under ' Rehabilitative Therapy (Physical Therapy, Occupational Therapy and Speech Therapy) Services' in the section of this Policy titled " Benefits/Coverage (What is Covered)".
- All Foreign Country Provider charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Benefits/Coverage (What is Covered)".
- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- Charges for which We are unable to determine Our liability because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby Physician.
- Charges for animal to human organ transplants.
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefit Exclusions

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

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved 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 under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Policy and require Prior Authorization. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this Policy;
- Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido/ and or sexual desire;
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational or Unproven as described in this Policy; except as specifically stated in the sections of this Policy titled “Clinical Trials” and any benefit language concerning “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals ;
- Implantable contraceptive products inserted by the Physician are covered under the Policy’s medical benefits
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies except for those pertaining to Diabetic Supplies and Equipment;
- Prescription vitamins other than prenatal vitamins, dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Medications used for travel prophylaxis, except anti-malarial drugs
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Any Drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician.
- Drug convenience kits;
- Prescriptions more than one year from the original date of issue;
- Any costs related to the mailing, sending or delivery of Prescription Drugs;
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Insured Person.

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 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 Policy benefit schedule);or
- Up to a 90 day supply, at a 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 90-Day Retail Pharmacy You can call the Customer Service number on Your ID card or go to www.cigna.com/ifp-providers (for detailed information about drug tiers please refer to the Policy benefit schedule).
- Up to a 90-day supply at Express Scripts Pharmacy, Cigna's home delivery Pharmacy for drugs 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 Policy benefit schedule).
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90 day supplies per Year.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Supplemental Drug Discount Program

You are responsible for paying 100% of the cost for any Prescription Drugs or Related Supplies excluded by this plan. However, the Supplemental Drug Discount Program allows participating pharmacies to charge You and Your Family Member(s) the discounted cost of non-covered Prescription Drugs and Supplies. This means you will pay 100% of the discounted cost, rather than the full cost, of Prescription Drugs and Supplies the plan does not cover. Please Note: the out-of-pocket costs that You and Your Family Member(s) pay for any Prescription Drugs or Related Supplies the plan does not cover will not be applied to the Insured Person's Deductible or Out-of-Pocket Maximum.

Pediatric Vision Benefit Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any Injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges in excess of the usual and customary charge for the Service or Material.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or Investigational or Unproven non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What Is Covered" within the Pediatric Vision Benefits section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What Is Covered." within the Pediatric Vision Benefits 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 or Investigational or Unproven 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

MEMBER PAYMENT RESPONSIBILITY

Benefit Schedule

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

The benefit schedule shows the Individual and Family Deductible and Out-of-Pocket Maximums and the maximum Covered Expense for each type of benefit.

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

In addition, no benefits are payable unless the Insured Person receives services from a Participating Provider, except as indicated below under "Special Circumstances".

Participating Hospitals, Participating Physicians and Other Participating Providers
Covered Expenses for Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to charge more than the Cigna Negotiated Rates for Covered Services. Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. In addition, Participating Providers will file claims with Us for the Insured Person, and will request Prior Authorization when it is required.

Be sure to check with the Provider prior to an appointment to verify that the Provider is currently contracted with Cigna.

Special Circumstances

This policy 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.

- **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**
  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.

Surprise Billing
You are responsible for applicable In-Network cost-sharing amounts, including Copayments, Deductibles and/or Coinsurance. If you receive services from a Non-Participating Provider or use services in a Non-Participating Hospital or other type of Non-Participating facility, you may have to pay additional costs associated with that care.

Non-Participating Hospitals, facilities or Providers often bill you the difference between what Cigna decides is the eligible charge and what the Non-Participating Provider bills as the total charge. This is called 'surprise' or 'balance' billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for Emergency Services is your plan's In-Network cost-sharing amounts, which are Copayments, Deductibles and/or Coinsurance. You cannot be balanced-billed for any other amount. This includes both the emergency facility and any Providers you may see for emergency care.

Non-Emergency Services at a Participating or Non-Participating Facility

The Hospital or facility must tell you if you are at a Non-Participating location or at a Participating location that is using Non-Participating Providers. It must also tell you what types of services may be provided by any Non-Participating Provider.

You have the right to request that Participating Providers perform all covered medical services. However, you may have to receive medical services from a Non-Participating Provider if a Participating Provider is not available. When this happens, the most you can be billed for **Covered Services** is your In-Network cost-sharing amount (Copayments, Deductibles and/or Coinsurance). These providers cannot balance bill you.

If you receive services from a Non-Participating Provider, Hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive non-Emergency Services from a Non-Participating Provider or facility, you may also be balance billed.
If you do receive a bill for amounts other than your Copayments, Deductible and/or Coinsurance, please contact us at the number on your ID card.

General Provisions

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

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

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

Pharmacy Payments

For Definitions associated with Prescription Drug benefits, refer to the 'Definitions' section of this Policy. Prescription Drug benefits are subject to the provisions within this section, and all other Policy provisions.

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Deductible C shown in the benefit schedule, and, once the Deductible is satisfied, subject to any applicable Copayments and/or Coinsurance shown in the benefit schedule. For additional information on the Deductible, please refer to the Definitions section of the Policy.

Cigna's Prescription Drug List is available upon request by calling the Customer Service number on your ID card or at www.cigna.com/ifp-drug-list.

In the event that you request a Brand Name Drug that has a Generic equivalent, you will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the cost of the Generic Drug, plus the Generic Copay or Coinsurance shown in the benefit schedule.

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.

Prescription Drugs Covered under the Medical Benefits

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

For certain Limited Distribution Drugs covered under the medical benefits of this Policy, the Provider who administers the drug must obtain the drug directly from a Cigna designated Limited Distribution Drug Provider, which may be a home delivery Pharmacy, 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 Medication and Infusion and Injectable Medication Benefits

Drugs Covered under the Prescription Drug Benefits

Self-Administered Injectable Medications, and syringes for the self-administration of those drugs, are covered under the Prescription Drug benefits of this Policy. 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 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.

Medications Covered under the Medical Benefits
Infusion and Injectable Medications on Cigna's Prescription Drug List are covered under the medical benefits of this Policy when Infusion and Injectable Medications on Cigna's Prescription Drug List are administered in a healthcare setting by a Physician or Other 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 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.

Split Fill Dispensing Program
This program applies for the first 30 days when you start a new therapy on certain Limited Distribution Drugs and Specialty Prescription Drugs. The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply of your Prescription Order for certain drugs filled at Accredo or Express Scripts, Our home delivery pharmacy instead of the full Prescription Order. You pay half the 30-day Cost-Share for this initial 15 day supply, and would be responsible for the other half of the 30-day Cost Share if an additional 15 day supply is provided. The therapeutic classes of Prescription Drugs that are included in this program are determined by Cigna and will be managed for continuation in this program as new clinical guidelines and dispensing experience dictates.

Prescription Drug List Management

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 Name 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 Family Member(s), regardless of its eligibility coverage under Your Policy, is a determination that is made by You (or Your Family Member) and the prescribing Physician.

The coverage status of a Prescription Drug or Related Supply may change periodically during the Year for various reasons. For example, a Prescription Drug or Related Supply 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 Supply may increase.

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

CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Medical Claims

How to File a Claim for Benefits

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

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

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 15 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

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

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

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

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

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

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

Payment of Claims: Any benefits payable under this Policy for Covered Services provided by a Participating Provider will be paid directly to that Participating Provider unless you direct otherwise, in writing, by the time proofs of loss are filed. Any benefits payable under this Policy for Covered Services provided by a Non-Participating Provider will be paid directly to you unless you direct otherwise, in writing, by the time proofs of loss are filed. In the event of your death, We will issue any benefits payable to you to the beneficiary of your estate as determined by applicable law.

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

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

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

Procedures Regarding Medical Necessity Determinations

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

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

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

Pre-service Medical Necessity Determinations

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

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

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

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

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

When an Insured Person or their representative requests a Medical Necessity determination after services have been rendered, Cigna will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the reason for the requested extensions and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

Post-service Claim Determinations

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

Notice of Adverse Determination

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

Prescription Drug Claims

Reimbursement/Filing a Claim

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

To purchase Prescription Drugs or Related Supplies from Express Scripts Pharmacy, Cigna’s home delivery Pharmacy, see the home delivery drug brochure on www.mycigna.com, or call the toll-free customer service number on the back of 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:
Express Scripts Pharmacy
P.O. Box 1019
St. Louis, MO 66301-6301
1-800-835-3784

Forms are also available online at myCigna.com.

The address to which you must mail paper claim forms is subject to change. Please check www.mycigna.com or call the toll-free customer service number on the back of our ID card to confirm the appropriate mailing address for any claim form you wish to send. If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of your ID card.

Pediatric Vision Claims

Reimbursement/Filing a Claim

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

Assignment of Pediatric Vision Claim Payments:

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

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

GENERAL POLICY PROVISIONS

Third Party Liability

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

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that you receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Insured Person (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Insured Person. Note: The coverage under this Policy is secondary to any automobile no-fault or similar coverage.

Our right to a lien on Your recovery is limited only to that amount in excess of Your full compensation for all damages arising out of the claim.

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

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

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

Alternate Cost Containment Provision

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

COORDINATION OF BENEFITS

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The plan that covers you as an enrollee or an employee shall be the Primary Plan and the plan that covers you as a dependent shall be the Secondary Plan;
- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee;
- If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

- then, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with custody of the child;
- then, the plan of the parent not having custody of the child, and
- finally, the plan of the spouse of the parent not having custody of the child.

- The plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan and the plan that covers you as a 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 Policy, 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 Policy 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 Policy 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.

Other Insurance With This Insurer

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

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

Medicare Enrollment

If an Insured Person is enrolled in 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. A person is considered enrolled in Medicare on the earliest date any coverage under Medicare becomes effective for him/her. 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.

Terms of the Policy

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

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

Circumstances Beyond Our 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 Covered Services, We will make a good faith effort to provide or arrange for the provision of the Covered Service taking into account the impact of the event.

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

If You did not purchase Your Policy from a Marketplace, or You purchased Your Policy from a Marketplace but did not elect to receive advanced premium tax credit (APTC), there is a grace period of 31 days during which Premiums may be paid without loss of coverage of any Premium due after the first Premium. 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 day of the grace period.

If You purchased Your Policy from a Marketplace and You have elected to receive advanced premium tax credit (APTC), there is a grace period of ninety (90) consecutive 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. However, if We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period.

Please see 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 Insured Persons 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.

Additional Programs: We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to You and Your Family Members for the purpose of promoting the general health and well-being of You and Your Family Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact Us for details regarding any such arrangements.

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

If this Policy is reinstated, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted Premium.

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

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

Renewal: This Policy renews on a Calendar Year basis.

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

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

Certificate of Creditable Coverage: If coverage under this Policy terminates for any Insured Person, We will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. An Insured Person may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Policy and for 24 months following termination of coverage. To obtain a certificate call the toll-free customer service number on the back of Your ID card. Such a certificate may help the Insured Person to obtain future coverage. However, Cigna is responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations made by any other health insurance issuer with respect to any coverage it provides, including whether or not, or to what extent, the information contained in the certificate is relevant to the other health insurance issuer's actions.

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

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

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

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

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

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

Identification Cards are issued by Cigna to Insured Persons are for identification only. Possession of the card does not guarantee coverage. To be entitled to coverage, the Insured Person must be enrolled and eligible at the time of service.

The relationship between Cigna and Participating Providers who are not employees of Cigna are independent contractor relationships. Such Participating Providers are not agents or employees of Cigna; and Cigna and its employees are not agents or employees of such Participating Providers. Cigna is not responsible for any claim for damages or injuries suffered by an Insured Person while receiving care from any Participating or Non-Participating Provider.

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

Cigna
Individual Services
P.O. Box 30365
Tampa, FL 3360-3365

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

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

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

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

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

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

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

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

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

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

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

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

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

Cigna reserves the right to:
Cigna reserves the rights to (i) change the rates chargeable under the policy and (ii) amend the terms of this policy 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.

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

TERMINATION/NON-RENEWAL/CONTINUATION

Specific Causes for Ineligibility:

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

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

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

Cancellation

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

1. You fail to pay Your Premiums as they become due or by the end of the 31 day grace period for plans not purchased from the Marketplace or the 90 consecutive day grace period for plans purchased from a Marketplace, or the 90 day grace period for insured persons receiving the Advanced Premium Tax Credit.
2. On the first of the month following Our receipt of Your written notice to cancel. If You purchased Your plan on a state exchange, We will cancel this Policy in accordance with Your written notice to cancel provided You provide notice at least fourteen days before the requested effective date of termination. If You provide Your written notice to cancel less than fourteen days before the requested date of termination, the effective date of termination will be no later than fourteen days after You provided the written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in Your class. In this event, Colorado law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person.
6. When We cease offering any plans in the individual market in Colorado, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation. Your coverage will be continued through Your first renewal period but not for more than 12 months after We send You the notice.
7. When the Policyholder no longer live in the Enrollment 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 Policy shall be subject to cancellation consistent with applicable federal and state law.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Policyholder's death, divorce or other reason for the Insured's ineligibility stated in the Policy or if other Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Policyholder's failure to pay Premium, the Family Member has the right to continuation of his or her insurance. Coverage will be continued if the Family Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability. Also, if an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, such termination would be considered a triggering event and the Insured Person could enroll during a special enrollment period if the Insured Person did not exercise their continuation right. The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will have coverage Effective Dates determined as follows: for an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; for an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month. Please see "Eligibility" for further information regarding Special Enrollment Periods.

APPEALS AND COMPLAINTS

WHEN YOU HAVE A COMPLAINT OR AN ADVERSE DETERMINATION APPEAL

Complaint and Appeal Process

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

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

Start with Customer Service

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

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

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

Appeals Procedure

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

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

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

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

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

Requests for appeal regarding an adverse determination of the Insured Person's issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a review will be conducted by someone who was a) not involved in any previous decision related to the Insured Person's appeal, and b) not a subordinate of previous decision makers.

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

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

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

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

Standard External Review Process for Medical Necessity Adverse Decisions

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

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

Within two working days of receiving the Insured Person's request for EIR from Cigna, the Commissioner will assign an independent external review entity to conduct the external review. Upon assignment, the Commissioner will notify Cigna, electronically, by facsimile, or by telephone, followed up in writing, of the name and address of the

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

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

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

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

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

Expedited External Review Process for Medical Necessity Adverse Decisions

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

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

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

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

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

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

Appeal to the State of Colorado

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

Colorado Division of Insurance
Department of Regulatory Affairs
1560 Broadway, Suite 850
Denver, CO 80202
1-800-930-3745

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit and (6) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient must be signed by a licensed physician/dentist familiar with standards of care in Colorado. A nurse or processor cannot sign a physician's/dentist's name 'on behalf of', a physician or dentist must sign, however an electronic signature is permitted. A final notice of adverse determination will include a discussion of the decision.

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

Relevant Information

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

INFORMATION ON POLICY AND RATE CHANGES

Premiums

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

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 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

You are required to pay Premiums for each Insured Person through the date that You notify Us that the Insured Person is no longer eligible or covered, except that if a Dependent is no longer covered because the Dependent becomes enrolled in the children's basic health plan, established pursuant to Article 8, Title 25.5, CRS, You must notify Us of the change in coverage at least 30 days prior to the date the Dependent will no longer be covered by Us

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

Cigna also reserves the right to change the Premium on 60 days' prior written notice to You. However, We will not modify the Premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new Premiums will indicate acceptance of the change.

Premiums are to be paid by You to Us.

Cigna will not accept the direct or indirect payment of Premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. 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 Policy.

DEFINITIONS

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

90-Day Retail Pharmacy is a Participating Retail Pharmacy that provides all the Covered Services of any other Participating Retail Pharmacy, and also, through an agreement with Cigna, or with an organization contracting on Cigna's behalf, dispenses up to a 90 Day supply of Prescription Drugs or Related Supplies, . Please note: not every Participating Pharmacy is a 90-Day Retail Pharmacy; however, every Participating Pharmacy can provide a 30-day supply of Prescription Drugs or Related Supplies.

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

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

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

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

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

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

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

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

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

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 Drug (Brand Name) means a Prescription Drug that Cigna identifies as a Brand Drug across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or biologics as either Brand or Generic based on a number of factors. Not all products identified as a "Brand Name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the Policy.

Business Decision Team is a committee comprised of voting and non-voting representatives across various business units of Cigna or its affiliates 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 Provider has contracted directly or indirectly with Cigna for a different amount, including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

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

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

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

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

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

Cost Share is the Deductible, Copayment and Coinsurance amounts You are responsible to pay under the Policy.

Covered Expenses are the expenses incurred for Covered Services under this Policy which Cigna will consider for payment under this Policy. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The Maximum Reimbursable Charge for Covered Services from Non-Participating Providers.

As determined by Cigna, Covered Expenses will include all Charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with Providers for the provision of any Covered Services.

Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that:

a. are listed in the benefit sections of this Policy, and

b. are not specifically excluded by the Policy, and

c. are provided by a Provider that is:

   (i) licensed in accordance with any applicable Federal and state laws,

   (ii) if a Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and

   (iii) acting within the scope of the Provider's license and (if applicable) accreditation.

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

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

Dedicated Virtual Care Medical Physician Service means a Virtual Care Service provided by a Dedicated Virtual Care Physician for minor acute medical conditions such as cold, flu, sore throat, rash or headache.

Dedicated Virtual Care Physician means a Physician who is part of a designated network from one or more organizations contracted with Cigna to provide Virtual Care Services.

Deductible means the amount of Covered Expenses that must be paid for Covered Services each year before benefits are available under this Policy.

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

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

Diabetic Pharmaceuticals and Supplies include test strips for blood glucose monitors; visual reading and urine test strips; blood glucose monitors on Cigna's Prescription Drug List; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

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

Durable Medical Equipment is defined as items which:

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

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

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

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

1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) serious impairment to bodily functions; or
3) serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(a) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and

(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

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

Essential Health Benefits: To the extent covered under this Policy, 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
- it is the subject of an on-going clinical trial, except as provided in the "Clinical Trials" section of this plan; 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 and one or more of your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Individual Deductible paid by each Family Member during a Year. Each Insured Person 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 section of this Policy

Family Member means Your spouse, children or other persons enrolled for coverage under this Policy. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled "Eligibility"

Family Out-of-Pocket Maximum: applies if You and one or more of Your Family Member(s) are enrolled for coverage under this Policy. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Insured Person can contribute up to his or her Individual Out-of-Pocket amount toward the Family Out of Pocket Maximum. Once the Family Out of Pocket Maximum has been met in a Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance or Copayments for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The amount of the Family Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.

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

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

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

Gene Therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each Gene Therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of Gene Therapy, based in part on the nature of the treatment and how it is distributed and administered.

Generic Drug (or Generic) means a Prescription Drug that Cigna identifies as a Generic Drug at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or biologics (including biosimilars) as either brand or generic based on a number of factors. Not all products identified as a “Generic” by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the Policy.

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

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

Home Health Agency means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal Social Security Act, as amended, for home health

agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.

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

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

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

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

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

Hospice Levels of Care means:

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

Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or
- an institution which qualifies as a Hospital, a psychiatric Hospital and a Provider of services under Medicare, if such institution is accredited as a Hospital for the appropriate treatment and/or diagnosis by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of mental health and Substance Use Disorder or other related Illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include any institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.

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

Individual Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services each Year before benefits are available under this Policy. The amount of the Individual Deductible is described in the Benefit Schedule section of this Policy.

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 Expenses received from Participating Providers, 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 from Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.

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

Infusion and Injectable Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional. Such medications may require Prior Authorization or Step Therapy. Refer to the “Prior Authorization Program” section of this Policy for Prior Authorization and Step Therapy information.

Injury means an accidental bodily injury.

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

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

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

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 delivered in the Emergency Department of a Non-Participating Hospital or facility when the facility is operated by the Denver Health and Hospital Authority,** the amount agreed to by the Non-Participating Provider or Hospital and Cigna, or if no amount is agreed to, **the greatest of**: (i) Cigna's Participating/In-Network median rate for the same service provided in a similar facility or setting in the same geographic area; (ii) 250% of the Medicare rate for the same service provided in a similar facility or setting in the same geographic area; or (iii) the median Participating/In-Network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all payer health claim database (APCD).
- **For Covered Expenses for Emergency Services delivered in the Emergency Department of a Non-Participating Hospital or facility when the facility is not operated by the Denver Health and Hospital Authority,** the amount agreed to by the facility and Cigna, or if no amount is agreed to, **the greatest of**: (i) 105% of Cigna's Participating/In-Network median rate for the same service provided in a similar facility or setting in the same geographic area; or (ii) the median Participating/In-Network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado all payer health claim database (APCD).
- **For Covered Expenses for Emergency Services, and non-Emergency Services, performed by a Non-Participating Provider in the Emergency Department of a Participating Hospital,** the amount agreed to by the Non-Participating Provider and Cigna, or if no amount is agreed to, **the greatest of**: (i) 110% of Cigna's Participating/In-Network median rate for the same service provided in the same geographic area; or (ii) the 60th percentile of the Participating/In-Network rate for the same service in the same geographic area for the prior year based on claims data from the Colorado all payer health claim database (APCD).

If the Non-Participating Provider does not agree that the Maximum Reimbursable Charge is sufficient for the complexity and circumstances of the services provided, the Provider may request arbitration pursuant to Colorado law. The Provider may not attempt to collect from you any amount in excess of applicable cost-sharing amounts based upon the Maximum Reimbursable Charge.

- **For Covered Expenses for non-Emergency Services, other than noted above, <u>the lesser of</u>:**
    1. The Provider's normal charge for a similar service or supply; or
    2. A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Not primarily for the convenience of any Insured Person, Physician, or another Provider.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:

i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and

ii) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

iii) For Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

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

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

Mental Health Disorder is defined as a condition that impairs the behavior, emotional reaction or thought processes; these include, but are not limited to: depression, psychosis, mania or other psychological symptoms.

Mental Health or Substance Use Disorder Residential Treatment Center means an institution which:

- specializes in the treatment of psychological and social disturbances that are the result of Mental Health and/or Substance Use Disorder conditions;
- provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians, other licensed healthcare professional under the direct supervision of a physician, or a healthcare professional independently licensed by a state to provide such services and working within the scope of his/her license (Physician Assistant, Nurse Practitioner);
- provides 24-hour care, in which a person lives in an open setting; and
- is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Negotiated Rate is the lesser of billed Charges or the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn is an infant within 31 days of birth.

Non-Participating Pharmacy/Out-of-Network Pharmacy is a retail or home delivery Pharmacy which Cigna has NOT contracted with to provide Prescription Drug services to Insured Persons.

Non-Participating Provider/Out-of-Network Provider is a Provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered.

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following 3 specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical Decision Making (the Physician's diagnosis and Policy of treatment)

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

Orthoses and Orthotic Devices are orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

Other Health Care Facility means a facility other than a Hospital or hospice facility which is operated by or has an agreement with Cigna to render services to Insured Persons. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and sub-acute facilities. Other Health Care

Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.

Other 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 Insured Persons. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.

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

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

Participating Pharmacy/In-Network Pharmacy is a retail Pharmacy which Cigna has contracted with to provide Prescription Drug services to Insured Persons; or Cigna's designated Home Delivery Pharmacy which Cigna has contracted with to provide home delivery Prescription Drug services to Insured Persons.

Participating Provider/In-Network Provider means:

- Hospitals, Physicians, and Other Health Care Facilities or Professionals, 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 Insured Persons; or
- For the purposes of reimbursement for Covered Expenses, an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with Providers for the provision of any services and/or supplies, the charges for which are Covered Expenses.

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

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

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

Pharmacy is a duly licensed pharmacy that dispenses Prescription Drugs or Related Supplies in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drugs and Related Supplies through mail order.

Pharmacy & Therapeutics (P & T) Committee is a committee comprised of both voting and non-voting clinicians 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, for example, 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.

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

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

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, and in the completed and accepted application for coverage.

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

Premium means the sum of money paid periodically to Cigna by You in order for You and Your Family Members to receive the services and benefits covered by the Policy.

Prescription Drug is a drug, biologic (including a biosimilar), or other Prescription Drug that has been approved by the U.S. Food and Drug Administration (FDA), certain Prescription Drugs approved under the Drug Efficacy Study Implementation review, or Prescription Drugs marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill. This definition includes Generic Drugs, Brand Name Drugs, and Specialty Medications.

Prescription Drug List is a listing of covered 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.cigna.com/ifp-drug-list.

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

Primary Care Physician (PCP) is a Physician:

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

Prior Authorization: means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Cigna for medical services and from the Pharmacy and Therapeutics Committee for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are Prescribed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this Policy. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Prescription Drug List at www.mycigna.com. HIV infection prevention drugs do not require Prior Authorization.

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; and
- terminal devices such as hands or hooks

Provider means:

- a Hospital, a Physician or any other Health Care Facility or 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; or
- an entity that directly or indirectly arranges, through contracts with other Providers, for the provision of any Covered Services.

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, medically necessary surgery, congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal

human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes, breast reconstruction incident to mastectomy or lumpectomy to restore or achieve breast symmetry. This includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Self-administered Injectable Medications 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 Insured Person.

Service Area means the area where Cigna has a Participating Provider network for use by this Policy. To locate a Provider who is Participating in the Network used by this Policy, call the toll-free number on the back of Your ID card, or check www.mycigna.com and click on “Find Care and Costs”

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

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

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

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

Specialty Medication is a pharmaceutical product, including Self-administered Injectable Medications and Infusion and Injectable Medications considered by Cigna to be a Specialty Medication based on the following factors, subject to applicable law:

- whether the Prescription Drug or pharmaceutical product is prescribed and used for the treatment of complex, chronic or rare conditions, and
- whether the Prescription Drug or pharmaceutical product has a high acquisition cost; and:
- whether the Prescription Drug or pharmaceutical product 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 Policy.

Specified Diabetic Services and Supplies are particular services and supplies provided or prescribed for the direct treatment of diabetes, including Diabetic Self-Management Training and Education, HbA1c, urinalysis, blood kidney function test for nephropathy, Metformin, diabetic retinal examination, test strips for blood glucose monitors; visual reading and urine test strips, lancets, syringes and needles. This does not include any other services or supplies not specifically listed here, even if such service or supplies is provided or prescribed for the direct treatment of diabetes, nor will these listed services be considered a Specified Diabetic Service or Supply if provided for the treatment of any other diagnosis.

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 an Insured Person to follow certain steps before covering some Prescription Drugs and Related supplies, including Specialty Medications. We may also require an Insured Person to try similar Prescription Drugs and Related Supplies, including Specialty Medications that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the Insured Person. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com. HIV infection prevention drugs or a covered Prescription Drug approved by the U.S. Food and Drug Administration or other recognized body for the treatment of stage four advanced metastatic cancer do not require Step Therapy.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. It causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Telehealth/Telemedicine Medical Services is a mode of delivery of health care services through HIPPA-compliant telecommunications systems, including information, electronic, communication technologies, remote monitoring technologies and store-and-forward transfers to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. Communications that are both audio and visual (not just audio or just visual) are considered telehealth.

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

Virtual Care Service is a suite of Covered Services delivered through audio, video and secure internet-based technologies.

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

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

896375a 05/17

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).