Cigna Health and Life Insurance Company

900 Cottage Grove Road
Bloomfield CT 06002

Individual Services – Utah
P.O. Box 30365
Tampa FL 33630-3365

Cigna Connect 1800 and Cigna Connect 1800-1

This Major Medical Expense Coverage Exclusive Provider Plan covers In-Network Services

POLICY FORM NUMBER: UTINDEPO062020

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Cigna Health and Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Policies of this category are not limited to basic hospital or basic medical insurance coverage.

Section I.

Coverage is provided by Cigna Health and Life Insurance Company (referred to herein as "Cigna"), an insurance company that provides participating provider benefits.

To **obtain additional information**, including Provider information write to the following address or call the toll-free number on the back of your ID card:

Cigna Health and Life Insurance Company
Individual Services - Utah
P.O. Box 30365
Tampa FL 33630-3365

An **Exclusive Provider Plan** enables the Insured to incur lower medical costs by using providers in the Cigna network.

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.

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.

Section II.

Covered Services and Benefits

Deductibles:

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. The Individual Deductible applies to all Covered Expenses, except for those covered under the Prescription Drugs section of this Policy; there is a separate Prescription Drug Deductible that applies only to those benefits.

Individual Prescription Drug Deductible means the amount of Covered Expenses each Insured Person must pay for Prescription Drugs and Related Supplies each Year before benefits are available for Prescription Drugs and Related Supplies under this Policy. The amount of the Individual Prescription Drug Deductible is described in the benefit schedule section of this Policy, in the Prescription Drug benefits.

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 Deductibles 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 Family Deductible applies to all Covered Expenses, except for those covered under the Prescription Drugs section of this Policy; there is a separate Prescription Drug Deductible that applies only to those benefits. The amount of the Family Deductible is described in the benefit schedule section of this Policy.

Family Prescription Drug 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 Prescription Drug Deductible paid by each Family Member during a Year. Each Insured Person can contribute up to the Individual Prescription Drug Deductible amount toward the Family Prescription Drug Deductible. Once the Family Prescription Drug Deductible amount is satisfied in a Year, any remaining Individual Prescription Drug Deductibles will be waived for the remainder of the Year. The amount of the Family Prescription Drug Deductible is described in the Prescription Drug section of the benefit schedule.

Out-of-Pocket Maximums:

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 Out-of-Pocket Maximum has been met for the Year, for Covered Expenses, you will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by you. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of this Policy.

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.

BENEFIT SCHEDULE

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!**

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 "How The Policy Works" section of Your Policy.

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** Deductible applies unless specifically waived.	 $1,800 $3,600
Prescription Drug Deductible	This plan has a separate Prescription Drug Deductible that applies only to Prescription Drugs and Related Supplies. This Prescription Drug Deductible does accumulate toward your Out-of-Pocket Maximum. PLEASE SEE THE PRESCRIPTION DRUG BENEFITS SECTION OF THIS SCHEDULE FOR THE AMOUNT OF THE PRESCRIPTION DRUG DEDUCTIBLE.
Coinsurance	20%
Out-of-Pocket Maximum **Individual** **Family**	 $8,000 $16,000

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 “Comprehensive Benefits: What the Policy Pays For” section of this Policy for additional details	0%, Deductible waived

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:
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. **Please be aware that the Pediatric Vision network is different from the network for Your medical benefits**	
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% per exam, Deductible waived
Eyeglasses and Lenses for Children	0% per pair, Deductible waived
Therapeutic Contact Lenses for Children Limited to one year's supply	0% per pair, Deductible waived
Elective Contact Lenses for Children Limited to one pair per Year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit.	0% per pair, Deductible waived
Physician Services **Office Visit**	
Primary Care Physician (PCP)	$15 Copayment per office visit, Deductible waived
Specialist (including consultant and second opinion services)	$60 Copayment per office visit, Deductible waived

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:
Other Physician Services	
Surgery in Physician's office	20%
Outpatient Professional Fees (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	20%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	20%
In-hospital visits	20%
Allergy testing and treatment/injections	20%
Virtual Care	
Dedicated Virtual Care Medical Physician Service for minor acute medical conditions	0%, 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.) Note: Any Prescriptions issued during a virtual visit are subject to all Prescription Drug benefits, limitations and exclusions.	Same benefit as when service provided in person

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:
Indian Health Program / Tribal Health Program Services* Any Covered Services provided by an Indian Health Program or Tribal Health Program Note: these benefits apply only to an Insured Person who is either a member of a federally-recognized Native American tribe or an Alaska Native and who is enrolled in a plan purchased through the Marketplace. *** see the Definitions section in the Policy for additional information on "Indian Health Program" and the "Tribal Health Program"**	0%, Deductible waived
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges **Emergency Admissions**	 20% 20% Benefits are shown in the Emergency Services schedule
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	20%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	20%

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:
All Other Laboratory and Radiology Services Facility and interpretation charges	
Physician's Office	20%
Free-standing Independent lab or x-ray facility	20%
Outpatient hospital lab or x-ray	20%
Rehabilitative Services Maximum of 20 visits per Insured Person, per Calendar Year for all therapies combined. Maximum does not apply to services for treatment of Autism Spectrum Disorders.	
Physical Therapy	20%
Occupational Therapy	20%
Speech Therapy	20%
Habilitative Services Maximum of 20 visits per Insured Person, per Calendar Year for all therapies combined. Maximums for rehabilitative services do not apply to Habilitative services.	
Physical Therapy	20%
Occupational Therapy	20%
Speech Therapy	20%
Note: Maximum does not apply to services for treatment of Autism Spectrum Disorders	

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:
Cardiac & Pulmonary Rehabilitation Maximum of 5 visits per Insured Person, per Calendar Year	20%
Women's Contraceptive Services, Family Planning and Sterilization	$0, Deductible waived
Male Sterilization	Copay or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery)/ Complications of Pregnancy	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office Visit benefit applies
Prenatal services, Postnatal and Delivery billed as "global" fee	20%
Hospital Delivery	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	Copay or Coinsurance applies for specific service provided
Postnatal visit or treatment billed separately from "global" fee	Copay or Coinsurance applies for specific service provided

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 "Comprehensive Benefits: What the Policy Pays For" section for specific information about what services are covered)	 PCP or Specialist Office Visit benefit applies 20% Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 30 days per Insured Person per Calendar Year for all facilities listed	20%
Home Health Care Services Maximum of 30 days per Insured Person, per Calendar Year	20%

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:
Durable Medical Equipment	20%
Prosthetics	20%
Hospice	
Inpatient	20%
Outpatient	20%
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	20%
Mental Health Disorder	
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
All other outpatient services	20%

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:
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	20%
Organ and Tissue Transplants	
Cigna LifeSOURCE Transplant Network® Facility	0%
Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services	Inpatient Hospital Services benefit applies
Participating Facility NOT specifically contracted to perform Transplant Services	Not Covered

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**	0%
Non-LifeSOURCE Participating Facility specifically contracted to perform Ventricular Assist Device Services	Inpatient Hospital Services benefit applies
Participating Facility NOT specifically contracted to perform Ventricular Assist Device Services	Not covered
Infusion and Injectable Medications and related services or supplies administered by a medical professional in an office or outpatient facility	20%
Specified Diabetic Services and Supplies	0%, Deductible waived

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
	Please note: In addition to the cost-sharing amounts described below, You may be responsible for additional charges including, but not limited to: (a) charges for non-Covered Services and (b) charges for services performed by Non-Participating Providers that are in excess of the Maximum Reimbursable Charge.	
• **Hospital Emergency Room**		
Emergency Medical Condition	$500 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	$40 Copayment, Deductible waived	In-Network Cost Share applies
Non-Emergency Medical Condition	$40 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	20%	20%

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
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.)	20%	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**	20%	In-Network Cost Share applies until transferable to an In-Network Hospital; if not transferred then Not Covered (You pay 100% of Charges)

BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	EXPRESS SCRIPTS PHARMACY, Cigna's HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Note: **You can obtain a 30 day supply of any 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 shown in this benefit schedule. For 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 $30 dollars per 30 day supply. Deductible will be waived.		
Prescription Drug Deductible	$500 Individual, $1,000 Family per Calendar Year	
	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.	$5 Copayment per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copay for each 30 day supply.	$15 Copayment per Prescription or refill, Deductible waived Up to a 90 day maximum supply
Tier 2: This tier typically includes most Generic Drugs and some low cost Brand Name Drugs. Generic Drugs have the same strength and active ingredients as Brand Name Drugs, but often cost much less.	$10 Copayment per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copay for each 30 day supply.	$30 Copayment per Prescription or refill, Deductible waived Up to a 90 day maximum supply

BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	EXPRESS SCRIPTS PHARMACY, Cigna's HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	20% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy	20% per Prescription or refill Up to a 90 day maximum supply
Tier 4: This tier typically includes non-preferred Brand Name Drugs and some high cost Generic Drugs.	50% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply – at a 90 Day Retail Pharmacy	50% per Prescription or refill Up to a 90 day maximum supply
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	40% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 30 day supply at a 90 Day Retail Pharmacy	30% per Prescription or refill Up to a 30 day maximum supply
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive, including but not limited to: ▪ women's contraceptives that are Prescribed by a Physician and Generic, or Brand Name with no Generic alternative available; and ▪ smoking cessation products, limited to a maximum of 2 90 day treatment regimens	0% per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy	0% per Prescription or refill, Deductible waived Up to a 90 day maximum supply

Section III.

Emergency Services and Benefits

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 at a Hospital Emergency Department 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.

Section IV.

Insured's Financial Responsibility

The Insured Person is responsible for paying the monthly premium on a timely basis. The Insured Person is also responsible to pay Providers for charges that are applied to the Deductibles, Copayments, Coinsurance and Penalties. In addition, any charges for Medically Necessary items that are excluded under this Policy are the responsibility of the Insured Person. Charges for a Non-Participating Provider (Out-of-Network), except for Emergency Services, are excluded from coverage under this Policy and are the responsibility of the Insured Person.

Limited Benefits

If you submit a claim for services which have a maximum limit we will only apply the allowed per day or per event amount (whichever applies) toward your Deductibles, or Out-Of-Pocket Maximums.

Section V.

Exclusions, Limitations, and Reductions

A. The Exclusive Provider Plan does not provide benefits for:

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition.
2. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this Policy.
3. Services **not specifically listed as Covered Services** in this Policy.
4. Services or supplies that are **not Medically Necessary**.
5. Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures or Unproven Procedures**.
6. Services **received before the Effective Date of coverage**.
7. Services **received after coverage under this Policy ends**.
8. Services **for which you have no legal obligation to pay** or for which no charge would be made if you did not have a health plan or insurance coverage.
9. 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.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any country**; (d) an Insured Person voluntarily **participating in an insurrection, rebellion, or riot;** (e) a loss directly related to the insured's **voluntary participation in an activity where the insured is found guilty of an illegal activity in a criminal proceeding**; or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance.
11. Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
12. Any **services required by state or federal law** to be supplied by a public school system or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
14. **If the Insured Person is enrolled 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.
15. **Court-ordered treatment or hospitalization**, unless such treatment is Medically Necessary and listed as covered in this Policy.

16. Professional **services or supplies received or purchased directly or on your behalf by anyone, including a Physician, from** any of the following:
    - Yourself or your employer;
    - A person who lives in the Insured Person's home, or that person's employer;
    - A person who is related to the Insured Person by blood, marriage or adoption, or that person's employer; 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.
17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this Policy.
18. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
19. **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.
20. 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.
21. **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.
22. 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.
23. 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.
24. **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.
25. **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.

26. **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.
27. 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.
28. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
29. **Routine hearing tests** except as provided under Preventive Care.
30. **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.
31. **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.
32. **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.
33. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
34. **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 or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
35. **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Policy.
36. Any treatment, prescription drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
37. All services related to **the evaluation or treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT).
38. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).

39. 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.
40. Blood administration **for the purpose of general improvement in physical condition.**
41. **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices.
42. **External and internal power enhancements** or power controls for prosthetic limbs and terminal devices.
43. **Myoelectric prostheses** peripheral nerve stimulators.
44. **Electronic prosthetic limbs or appliances** unless Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience, when a less-costly alternative is not sufficient.
45. **Prefabricated foot Orthoses**.
46. **Cranial banding/cranial orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
47. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
48. **Orthoses primarily used for cosmetic** rather than functional reasons.
49. **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.
50. 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.
51. **Treatment that will not result in a favorable modification** or prevent deterioration.
52. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna.
53. **Nutritional counseling** except when provided as part of the Preventive Care Services, Treatment of Diabetic Services or Mental Health Services stated in this Policy.
54. **Food Supplements,** except as stated in this Policy.

55. **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.

56. **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under "Services for Rehabilitative Therapy (Physical Therapy, Occupational Therapy and Speech Therapy)" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For".

57. All **Foreign Country Provider charges** are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For".

58. **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 when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous or as otherwise stated in this Policy.

59. **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.

60. Charges for **chiropractic treatment.**

61. Charges for services for **Temporomandibular Joint Dysfunction (TMJ).**

62. Charges for **dental care, including accidental Injury to natural teeth.**

B. The Exclusive Provider Plan does not provide Prescription Drug Benefits for:

- 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 by the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;

- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
- 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.

C. The Exclusive Provider Plan limits Prescription Drug Benefits for:

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

- Up to a 30 supply, at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 30 day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Policy benefit schedule).
- 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 Script's home delivery Pharmacy for drug tiers 1 through 4 and up to a 30 day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the 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.

D. The Exclusive Provider Plan does not provide Pediatric Vision Benefits for:

- 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, except as stated in the Policy.
- Experimental or Investigational or Unproven or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.

- Spectacle lens treatments, “add ons”, or lens coatings not otherwise listed in “What’s Covered.” within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- 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.

Section VI.

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.

Section VII.

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 <u>INPATIENT</u> SERVICES

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

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

To verify Prior Authorization requirements for Prescription Drugs and 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.

Section VIII.

Complaint Resolution Procedures

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

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

Start With Customer Service

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

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

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

Level-One Appeal

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

For level-one appeals, We will respond in writing with a decision within 15 calendar days after We receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, We will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to Your medical condition. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with Our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of medical necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer 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 second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify you 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 level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 30 days, unless the review is expedited. An expedited independent review is available if the adverse benefit determination: (a) involves a medical condition which would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; (b) in the opinion of the your attending provider, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or (c) concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility. The independent Review Organization will as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision to uphold or reverse the adverse benefit determination.

The Independent Review Program is a voluntary program arranged by Cigna.

Assistance to the State of Utah

You have the right to contact the Utah State Department of Insurance for assistance at any time. The Utah State Department of Insurance may be contacted at the following address and telephone number:

Utah State Department of Insurance
State Office Building, Room 3110
Salt Lake City, UT
84114-6901
800-439-3805

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: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; 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 information about any office of health insurance consumer assistance or ombudsman available to assist You in the appeal process. A final notice of adverse determination will include a discussion of the decision.

Relevant Information

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

Section IX.

Participating Providers

Cigna will provide a current list of physicians and other health care providers currently participating with Cigna and their locations to each Insured Person upon request.

To verify if a physician or other health care provider is currently participating with Cigna and is accepting new Cigna Insured's, the Insured should contact the Customer Service Unit at the number on the back of your ID card, or visit our website, www.cigna.com.

Section X.

Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy.

2. The Policy is designed for residents of the state of Utah. The Policyholder must notify Cigna of all changes that may affect any Insured Person's eligibility under the Policy.

3. An Insured Person will become ineligible for coverage:

- 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 the Insured Person, when you no longer meet the requirements listed in the Conditions of Eligibility Requirements section.
- The date the Policy terminates.
- When the Insured Person no longer lives in the Enrollment Area.

4. If an Insured Person's eligibility under this Policy would terminate due to the Policyholder's death, divorce or if other Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Policy; except for the Policyholder's failure to pay Premium, that 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.

Section XI.

Premium

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

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 45 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. We will only change Premiums on an Annual basis. 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.

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.