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. We will only change Premiums on an Annual basis.

Cigna Health and Life Insurance Company (Cigna Healthcare)

Connect Silver-2 SW 2700 Indiv Med Deductible

Effective Date: 1/1/2026

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 Healthcare
Individual Services
PO Box 30028
Tampa FL 33630-3028

Include your Cigna Healthcare identification number with any correspondence. This number can be found on your Cigna Healthcare 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 Healthcare) 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 Healthcare 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 Healthcare by:



Bruce M. Grimm, President



Alicia Morrow, Corporate Secretary

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

You do not need Prior Authorization from the plan or from any other person (including 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 requires 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. Cigna Healthcare will 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.

New Protections for You and Your Family Members

If you receive care from an Out-of-Network Provider or facility, your health plan may not cover the entire cost. As a result, you may be left with higher costs than if you received care from an In-Network Provider or facility. In the past, in addition to any out-of-network cost-sharing you may owe, the Out-of-Network Provider or facility could bill you for the part of the bill that your health plan did not pay, resulting in a balance bill. An unexpected balance bill from an Out-of-Network Provider or facility is also called a surprise medical bill.

Starting in January 2022, new rules went into effect to protect you from surprise medical bills. These rules are sometimes called the “No Surprises” rules. These rules:

- Ban surprise medical bills for Emergency Services, even if you get them out-of-network and without approval beforehand (Prior Authorization).
- Ban out-of-network cost-sharing (like out-of-network Coinsurance or Copayments) for all Emergency and some non-Emergency Services. You can’t be charged more than in-network cost-sharing for these services.
- Ban out-of-network cost-sharing (like out-of-network Coinsurance or Copayments) for all Emergency and some non-Emergency Services. You can’t be charged more than in-network cost-sharing for these services.
- Ban out-of-network Charges and balance bills for supplemental care (like anesthesiology or radiology) by Out-of-Network Providers who work at an in-network facility.
- Require that health care Providers and facilities give you an easy-to-understand notice explaining that getting care out-of-network could be more expensive and options to avoid balance bills. You’re not required to sign this notice or get care out-of-network.

Also starting in January 2022, if you think your health plan’s decision to not pay part or all of a claim violates the new surprise billing protections, you can appeal that decision. You can use the external review process described in your plan documents and denial notices to request the external review of your plan’s decision.

If you have a question about these new rules or believe the rules aren’t being followed, contact the “No Surprises” Help Desk at 1-800-985-3059 or submit a complaint online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

TABLE OF CONTENTS

INTRODUCTION 1

IMPORTANT INFORMATION REGARDING BENEFITS 5

BENEFIT SCHEDULE 7

DEFINITIONS 23

WHO IS ELIGIBLE FOR COVERAGE? 38

HOW THE POLICY WORKS 46

COMPREHENSIVE BENEFITS: WHAT THE POLICY PAYS FOR 49

EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY THIS POLICY 68

PRESCRIPTION DRUG BENEFITS 73

PEDIATRIC VISION CARE 84

GENERAL PROVISIONS 86

PREMIUMS 103

Introduction

About This Policy

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

Under this Policy, "We," "Us," and "Our" mean Cigna Healthcare. "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 Healthcare 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 OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE 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 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA HEALTHCARE. 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 HEALTHCARE 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 HEALTHCARE 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 Policy except as shown in the section titled "Special Circumstances."

THIS IS AN EXCLUSIVE PROVIDER POLICY

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

- Services for Stabilization and initial treatment of an Emergency Medical Condition, 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 (PCP)

When you enroll as an Insured Person, you must choose a Primary Care Physician (PCP). If you do not select a PCP, We will assign one for you. If your PCP leaves the Cigna network, you will be able to choose a new PCP.

A Primary Care Physician serves 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 should 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 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 www.mycigna.com, under your name, click on "My Health Team," click "Change," 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 Provider, 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, specialist, or facility ceases to be a Participating Provider, We will notify you. Under certain medical circumstances, We may continue to reimburse Covered Expenses from your facility, 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 Healthcare's network. If you are undergoing a course of treatment for a Serious and Complex Condition; or undergoing a course of institutional or inpatient care; or scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to such a surgery; or determined to be terminally ill and are receiving treatment for such illness, 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 pregnant and undergoing a course of treatment for the pregnancy, in which 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 Healthcare, and your Provider must agree to accept Our reimbursement rate and to abide by Cigna Healthcare'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 Healthcare after your Participating Provider's termination from Cigna Healthcare'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:

- The 90-day period beginning on the date on which notice was provided to you that your PCP, specialist or facility will no longer be a Participating Provider; or
- The date on which you are no longer a continuing care patient with respect to your PCP, specialist or facility.

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

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

Important Information Regarding Benefits

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY 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 Healthcare 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 Healthcare 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’s 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 Healthcare will use retrospective review to determine if a scheduled admission was Medically Necessary. Cigna Healthcare will also use retrospective review to determine if an 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 Healthcare 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 Healthcare at the number on the back of your ID card, or
- log on to www.cigna.com/ifp-drug-lists.

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 Healthcare for the particular service or therapy, and will not be covered if you receive them from any other Provider regardless of participation status.

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 Healthcare. 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 as stated in the section of the Policy titled "Special Circumstances."

IMPORTANT NOTE ON MENTAL HEALTH & SUBSTANCE USE DISORDER COVERAGE:
Covered Services which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be covered at the Cost Share shown in the sections titled "Mental Health Disorder" and "Substance Use Disorder" within the benefit schedule below. Any age, day, dollar or visit maximums are not applicable to services used to diagnose or treat a Mental Health or Substance Use Disorder condition.

Covered medical services received for ambulance Charges provided for Mental Health or Substance Use Disorders will be payable according to the benefits outlined in "Hospital Emergency Room" within the benefit schedule below.

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	$2,700
Family	$5,400
Deductible applies unless specifically waived.	
Coinsurance	50%
Out-of-Pocket Maximum	
Individual	$8,450
Family	$16,900

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** **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 Healthcare 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 inpatient admissions. Failure to do so may result in a penalty or denial of payment for services provided. **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 Care Services Please refer to "Comprehensive Benefits: What the Policy Pays For" section of this Policy for additional details	0%, Deductible waived
Pediatric Vision Care Performed by an ophthalmologist or optometrist for an Insured Person through the end of the month in which the Insured Person turns 19 years of age. Please be aware that the pediatric vision network is different from the network of your medical benefits. **Comprehensive Eye Exam** Limited to one exam per Year **Eyeglasses for Children** Limited to one pair per Year Pediatric Frames, Single Vision, Lined Bifocal, Lined Trifocal or Standard Progressive and Lenticular Lenses **Contact Lenses for Children** Annual limits apply Elective and Therapeutic **Low Vision Services and Aids** Annual limits apply	 0%, Deductible waived 0%, Deductible waived 0% per pair, Deductible waived 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
Physician Services	
Office Visit or House Call	
Primary Care Physician (PCP)	$15 Copayment per visit, Deductible waived
Specialist (including consultant and second opinion services)	$40 Copayment per visit, Deductible waived
Other Physician Services	
Surgery in Physician's office	50%
Outpatient Professional Fees (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	50%
In-Hospital visits	50%
Allergy testing and treatment/injections	50%

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
Virtual Care and Telehealth Services **Dedicated Virtual Urgent Care** for minor acute medical conditions **Dedicated Virtual Primary Care** for routine medical conditions **Telehealth Services from Participating Physicians other than Dedicated Virtual Care Physicians** Note: Any Prescription issued during a virtual visit is subject to all Prescription Drug benefits, limitations and exclusions.	$0 Copayment per visit, Deductible waived PCP Office Visit benefit applies Same benefit as when service provided in person
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

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
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges **Emergency Admissions** Facility Charges Professional Charges	50% 50% Benefits are shown in the Emergency Services schedule
Outpatient Facility Services Including diagnostic facilities, outpatient Hospital facilities and Free-Standing Outpatient Surgical Facilities	50%
Advanced Radiological Imaging (including MRIs, MRAs, CAT scans, PET scans) Facility and interpretation Charges	50%
All Other Laboratory and Radiology Services Facility and interpretation Charges **Physician's Office** Lab X-ray **Free-standing** Independent Lab X-ray Facility **Outpatient Hospital** Lab X-ray	 50% 50% 50% 50% 50% 50%

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 Services Maximums for Habilitative Services do not reduce maximums for rehabilitative services.	
Physical Therapy Maximum of 20 visits per Insured Person, per Calendar Year	50%
Occupational Therapy Maximum of 20 visits per Insured Person, per Calendar Year	50%
Speech Therapy Maximum of 20 visits per Insured Person, per Calendar Year	50%
Chiropractic Treatment Maximum of 12 visits per Insured Person, per Calendar Year	50%
Cardiac Rehabilitation Maximum of 36 visits per Insured Person, per Calendar Year. Limits based on medical necessity guidelines.	50%
Pulmonary Rehabilitation Maximum of 20 visits per Insured Person, per Calendar Year. Limits based on medical necessity guidelines.	50%

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
Habilitative Services Maximums for rehabilitative services do not reduce maximums for Habilitative Services. **Physical Therapy** Maximum of 20 visits per Insured Person, per Calendar Year **Occupational Therapy** Maximum of 20 visits per Insured Person, per Calendar Year **Speech Therapy** Maximum of 20 visits per Insured Person, per Calendar Year	50% 50% 50%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	50%
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 Office 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 50% Inpatient Hospital Services benefit applies Copayment or Coinsurance applies for specific service provided Copayment 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)	 Mental Health Disorder Office Visit benefit applies 50% 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 90 days per Insured Person, per Calendar Year for all facilities listed.	50%
Home Health Care Services Maximum of 100 visits per Insured Person, per Calendar Year Note: Maximum does not include home infusion therapy or home private duty nursing.	50%
Private Duty Nursing Maximum of 82 visits per Insured Person, per Calendar Year	50%
Durable Medical Equipment	50%
Prosthetics	50%

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
Hospice	
Inpatient	50%
Outpatient	50%
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	50%
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	$35 Copayment per visit, Deductible waived
All other outpatient services	50%

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	$35 Copayment per visit, Deductible waived
All other outpatient services	50%
Organ and Tissue Transplants	
Cigna LifeSOURCE Designated Transplant Network® Facility	0%
Travel expenses (only available through Cigna LifeSOURCE Designated Transplant Network® Facility) Travel expenses are $10,000 per Insured Person, per transplant	
Unrelated donor search for bone marrow/stem cell transplant, covered up to $30,000. Prior Authorization required.	
All other participating or non-participating facilities not identified as Cigna LifeSOURCE Designated Transplant Network® Facility	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 Designated Transplant Network® Facility** **All other participating or non-participating facilities not identified as Cigna LifeSOURCE Designated Transplant Network® Facility**	0% Not Covered
Infusion and Injectable Medications and related services or supplies Administered by a medical professional in an office or outpatient facility	50%
Dental Care (other than Pediatric) Limited to treatment for accidental Injury to natural teeth within 12 months of the accidental Injury	50%
Wigs Maximum of 1 wig per Insured Person, per Calendar Year	50%
Surgical Bras Maximum of 4 surgical bras per Insured Person, per Calendar Year	50%

BENEFIT INFORMATION	What You Pay For **Participating Providers** based on the Negotiated Rate for Covered Expenses	What You Pay For **Non-Participating Providers** based on the Allowed Expense for Covered Expenses
Note: Covered Services are subject to applicable Deductible unless specifically waived.	Please note: In addition to the cost sharing amounts described below, you may be responsible for additional Charges including, but not limited to Charges for non-Covered Services.	
Urgent Care Center Facility		
Urgent Health Problem	$35 Copayment per visit, Deductible waived	In-Network Cost Share applies
Non-Urgent Health Problem	$35 Copayment per visit, Deductible waived	Not Covered (You pay 100% of Charges)

BENEFIT INFORMATION	What You Pay For **Participating Providers** based on the Negotiated Rate for Covered Expenses	What You Pay For **Non-Participating Providers** based on the Allowed Expense for Covered Expenses
Emergency Services **This Policy covers Emergency Services from Participating and Non-Participating Providers; Covered Services are subject to applicable Deductible unless specifically waived.**	**Please note:** With respect to the cost sharing amounts shown below, you will be responsible for only the amount of Non-Participating Provider Covered Expenses that you would have incurred if you received the services from an In-Network Provider. We will ensure that you are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance you would have paid had you received the services from a Participating Provider, and as such benefits will be provided to you at no greater cost than if you received them from a Participating Provider. You are also responsible for all Charges that are not Covered Expenses under this Policy.	
Hospital Emergency Room **Emergency Medical Condition**	50%	In-Network Cost Share applies
Non-Emergency Medical Condition	Not Covered (You pay 100% of Charges)	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	50%	In-Network Cost Share applies
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 transferable to a participating facility. Non-Participating Provider benefits are not covered once the patient is transferable to a participating facility.)	50%	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	50%	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	Cigna Healthcare's HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Note: **You can obtain a 30-day supply of any covered Prescription Drug or Related Supply at any retail Participating Pharmacy.** **For tiers 1 through 4, 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 one of Cigna Healthcare's home delivery pharmacies, Express Scripts Pharmacy, or Evernorth EnGuide Pharmacy, for select Prescription Drugs.** 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 Brand Copayment or Coinsurance shown in this benefit schedule.		
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 Healthcare Retail Pharmacy Drug Program YOU PAY:	**Cigna Healthcare's Home Delivery Pharmacy YOU PAY:**
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.	$3 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.	$7.50 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.	$25 Copayment, Deductible waived per Prescription or refill 30-day supply at any Participating Pharmacy or Up to a 90-day supply at a 90 Day Retail Pharmacy You pay a Copayment for each 30-day supply.	$62.50 Copayment, Deductible waived per Prescription or refill Up to a 90-day maximum supply

BENEFIT INFORMATION	RETAIL PHARMACY	Cigna Healthcare's HOME DELIVERY PHARMACY
	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.	$90 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.	$225 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.	49% per Prescription or refill 30-day supply at any Participating Pharmacy or Up to a 90-day supply at a 90 Day Retail Pharmacy	49% per Prescription or refill Up to a 90-day maximum supply

BENEFIT INFORMATION	RETAIL PHARMACY	Cigna Healthcare's HOME DELIVERY PHARMACY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	50% per Prescription or refill 30-day supply at any Participating Pharmacy or Up to a 30-day supply at a 90 Day Retail Pharmacy	50% 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

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 retail Participating Pharmacy that provides all the Covered Services of any other retail Participating Pharmacy, and also, through an agreement with Cigna Healthcare, or with an organization contracting on Cigna Healthcare'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 XXVI 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 publicly 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.

Allowed Expense is the amount that Cigna Healthcare may cover for services rendered by a Non-Participating Provider consistent with applicable law.

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

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

Athletic Trainer means a person licensed under applicable Indiana state law providing rehabilitative services within their scope of practice.

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 relationship 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 disorders not otherwise specified.

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 Healthcare 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.

Charges means the actual billed charges, except when the Provider has contracted with Cigna Healthcare for a different amount, including where Cigna Healthcare has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

Children's Health Insurance Program (CHIP) means an insurance program that provides health coverage to eligible children that do not otherwise qualify for Medicaid.

Chronic Pain means pain that:

- persists beyond the usual of an acute disease or healing of an Injury;
- or may be associated with an acute or chronic pathologic process that causes continuous or intermittent pain for a period of months or years.

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

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

Cigna Vision is a designated product administered by Us that provides vision services performed by an ophthalmologist or optometrist for Pediatric Vision Care under this plan.

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

Copayment 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.

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 Healthcare will consider for payment under this Policy. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The Allowed Expense.

As determined by Cigna Healthcare, Covered Expenses will include all charges made by an entity that has contracted with Cigna Healthcare 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) 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 Physician means a Physician who is part of a designated network from one or more organizations contracted with Cigna Healthcare to provide certain Virtual Care Services.

Dedicated Virtual Primary Care means a Virtual Care Service provided by a Dedicated Virtual Care Physician for routine primary care needs for conditions such as diabetes, hypertension, cholesterol, asthma, or other non-urgent issues.

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

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, monitors designed to be used by blind persons; insulin pumps and associated appurtenances, 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; and podiatric appliances for the prevention of complications associated with diabetes. Diabetic Equipment also includes 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 visual reading and urine test strips; ketones and protein test strips; blood glucose monitors, therapeutic continuous glucose monitors and the associated supply items on Cigna Healthcare's Prescription Drug List; lancets and lancing devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection; syringes and hypodermic needles, prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

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

Durable Medical Equipment is defined as items which:

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

Such equipment includes, but is not limited to, crutches, Hospital beds, wheelchairs, 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, including a Mental Health Disorder or Substance Use Disorder manifesting 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:

- 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;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

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

- a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

Essential Health Benefits: 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 and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II, III or IV 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 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 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 "Who is Eligible for Coverage?"

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. 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 means an Institution which meets all of the following requirements:

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

Generic Drug (Generic) means a Prescription Drug that Cigna Healthcare 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 those services that are:

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

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

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

Health Plan Value Assessment Committee (HVAC) is a committee comprised of voting and non-voting representatives across various business units of Cigna Healthcare or its affiliates that is duly authorized by Cigna Healthcare 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.

Home Health Agencies and Visiting Nurse Associations are home health care Providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home. They must be approved as home health care Providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Program means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual, and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the Illness; a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services means palliative and supportive medical, nursing, and other health services through home or inpatient care that are Covered Expenses provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar Institution, (c) a Home Health Agency and Visiting Nurse Association, (d) a hospice facility, or (e) any other licensed facility or agency under a Hospice Care Program.

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.

Indian Health Program is only applicable to an Insured Person who is a Native American or Alaska Native, and is defined as follows:

- any health program administered directly by the Indian Health Service;
- any Tribal Health Program; and
- any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 47 of US Title 25, Chapter 2.

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 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.

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 Specialty Medications may require Prior Authorization or Step Therapy. Refer to the “Prescription Drug Benefits” 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.

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.

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 Healthcare to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Not primarily for the convenience of any Insured Person, Physician, or another Provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna Healthcare 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 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 Health Care Professionals 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 Healthcare 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 Healthcare 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 specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical decision making (the Physician's diagnosis and plan of treatment)

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

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 Healthcare 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 Healthcare to render services to Insured Persons. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses, certified nurse anesthetist 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 in a Year.

Participating Pharmacy/In-Network Pharmacy is a retail Pharmacy which Cigna Healthcare has contracted with to provide Prescription Drug services to Insured Persons or Cigna Healthcare's designated home delivery Pharmacy which Cigna Healthcare 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 Healthcare, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna Healthcare to provide services to Insured Persons; or
- For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna Healthcare to arrange, through contracts with Providers for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

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 Care is examinations and materials (frame and lenses) provided to an Insured Person through the end of the month in which the Insured Person turns 19 years of age. Please refer to the "Pediatric Vision Care" section of this Policy for additional details.

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 and Therapeutics (P&T) Committee is a committee comprised of both voting and non-voting clinicians that represent a range of clinical specialties and a minimum of one patient representative. 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 Health Plan Value Assessment Committee (HVAC) 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 biomedical journals.

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

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

Policy is the set of benefits, conditions, exclusions, limitations, and Premiums described in this document, including the Policy specification page, the completed and accepted application for coverage, and any amendments or endorsements to this document.

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 Healthcare 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 Health Plan Value Assessment Committee (HVAC). The Prescription Drug List is regularly reviewed and updated. You can view the drug list at www.mycigna.com.

Prescription Order (Prescription) 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, or designated by Cigna Healthcare, 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 Healthcare 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.

Prostheses/Prosthetic Appliances and Devices (Prosthetics) are artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:

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

Provider means**:**

- a Hospital, a Physician, or an Other Health Care Facility or Professional (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 Healthcare, 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, 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.

Serious and Complex Condition means with respect to an Insured Person:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- a chronic illness or condition that is:
    - life-threatening, degenerative, potentially disabling, or congenital, and
    - that requires specialized medical care over a prolonged period of time.

Service Area is any place that is within the counties, cities and/or zip code areas in the state of Indiana that has been designated by Cigna Healthcare as the area where this Policy is available for enrollment, and the area where Cigna Healthcare has a majority of Our Participating Providers 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.

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

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

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

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

Specialty Medication is a pharmaceutical product, including Self-administered Injectable Medications and Infusion and Injectable Medications considered by Cigna Healthcare 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;
- 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.

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 medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

Step Therapy is a type of Prior Authorization. Cigna Healthcare 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.

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 Services means health care services delivered by use of technology allowed under Indiana law, including medical exams and consultations, and behavioral health including Substance Use Disorder evaluations and treatment.

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.

Tribal Health Program means, with respect to an Insured Person who is a Native American or an Alaska Native only, an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

Urgent Health Problem means a medical condition that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life (i.e., is not an Emergency Medical Condition).

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

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

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

Who Is Eligible For Coverage?

Eligibility Requirements

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 Indiana; and
- You live in the Service 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 who lives in the Service Area.
- Your children until the end of the plan Year in which the child reaches age 26.

  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 Family Member 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** will be considered adopted from the earlier of: (1) the date of placement for adoption; or (2) the date of the entry of an order granting custody of the child to You, is automatically covered for 31 days. To continue coverage past that time, You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the date of adoption, and pay any additional Premium. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption. A child who is placed with You for **foster care** is automatically covered for 31 days from the date of the foster child's placement. To continue coverage past that time, You must enroll the foster child as a Family Member by applying for his or her enrollment as a dependent within 60 days of the date the child is placed with You for foster care, and pay any additional Premium. Coverage for a foster child enrolled within 60 days of placement for foster care will be retroactive to the date of the child's placement for foster care.

  A child for whom You have **legal guardianship** is automatically covered for 31 days from the date of the placement. 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 the child is placed with You for legal guardianship, and pay any additional Premium. Coverage for a child enrolled within 60 days of placement will be retroactive to the date of the child's placement.

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 Family Member within 60 days of the court order date, and pay any additional Premium. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order.

- Your **stepchildren** until the end of the plan Year in which the stepchild reaches age 26.
- Your own, or Your spouse's **children**, regardless of age, enrolled prior to age 26, who are incapable of self-support due to medically certified continuing mental, intellectual or physical disability, and are chiefly dependent upon the Insured Person for support and maintenance. Cigna Healthcare may require written proof of such disability and dependency within 31 days prior to the end of the Year in which the child reaches age 26.

NOTE: A child enrolled as a Family Member under this Policy 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 special enrollment period during which an eligible person can enroll and an Insured Person can add dependents and change coverage.

The Annual Open Enrollment Period and special enrollment period are explained below.

Annual Open Enrollment Period

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

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

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

Special Enrollment Periods

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

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

Triggering events for a special enrollment period OFF Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage including Medicaid or Children's Health Insurance Program (CHIP); or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage (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), birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order; or

- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan (QHP) is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to a new QHP as a result of a permanent move (including a move outside the Service Area of the individual's current plan); or
- A qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator; or
- 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.

In most cases, the special enrollment period begins on the date the triggering event occurs and ends on the 61st day following the triggering event. In certain cases, an individual may also qualify for a special enrollment period during the 60 days leading up to the triggering event. In certain cases, an individual may also qualify for a special enrollment period during the 60 days leading up to the triggering event and up to 90 days following the loss of Medicaid or CHIP. Persons who enroll during a special enrollment period will have coverage Effective Dates determined as follows:

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

For all other triggering events the Effective Date will be the first day of the following month.

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage including Medicaid or Children's Health Insurance Program (CHIP), pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per Calendar Year), or the qualified individual or dependent is enrolled in any non-Calendar Year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-Calendar Year insurance is the last day of the plan or policy year; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage (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), birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- An eligible individual, 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; or
- At the option of the Marketplace, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- A qualified individual or dependent becomes newly eligible for enrollment in a QHP when they satisfy the Marketplace's citizenship requirement or are released from incarceration; or
- An eligible individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual's enrollment in a QHP was influenced by a material error related to plan benefits, Service Area, cost sharing or Premium; or

- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan:
    - The enrollee or dependent is determined newly eligible or ineligible for the advanced premium tax credit (APTC) or has a change in eligibility for cost sharing reductions;
    - A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;
    - A qualified individual who was previously ineligible for APTC because of a household income below 100% of the federal poverty level (FPL) and who was also ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, either experiences a change in income or moves to a different state, making them newly eligible for APTC.
- The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to a new QHP as a result of a permanent move (including a move outside the Service Area of the individual's current plan) and either (1) had minimum essential coverage for one or more days during the 60 days preceding the date of the move, or (2) was living outside of the United States; or
- The qualified individual who gains or maintains status as an Indian or an Alaska Native, as defined by section 4 of the Indian Health Care Improvement Act (or their dependent), may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or
- An eligible individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the Marketplace may provide; or
- A qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator; or
- A qualified individual or dependent applies for Marketplace or Medicaid or CHIP coverage during open enrollment or due to a qualifying life event, but is determined ineligible for Medicaid or CHIP after the exchange Annual Open Enrollment Period has ended or more than 60 days after a qualifying life event; or
- The qualified individual or enrollee (or their dependent) adequately demonstrates to the Marketplace that a material error related to plan benefits, Service Area or Premium influenced their decision to purchase a QHP; or
- At the option of the Marketplace, the qualified individual provides satisfactory evidence to verify eligibility for an insurance affordability program or enrollment in a QHP following termination of exchange enrollment due to a failure to verify such status within established time periods, or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify citizenship, status as a national or lawful presence; or

- 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.

In most cases, the special enrollment period begins on the date the triggering event occurs and ends on the 61st day following the triggering event. In certain cases, an individual may also qualify for a special enrollment period during the 60 days leading up to the triggering event. In certain cases, an individual may also qualify for a special enrollment period during the 60 days leading up to the triggering event and up to 90 days following the loss of Medicaid or CHIP. Persons who enroll during a special enrollment period will have coverage Effective Dates determined as follows:

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care; or
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, and plan selection is made on or before the last day of the month preceding the triggering event, coverage Effective Date is the first day of the month in which the triggering event occurs. If the plan selection is after the triggering event, coverage Effective Date is the first day of the following month; or
- In the case where a qualified individual loses employer contribution or government subsidies for COBRA and plan selection is made on or before the last day of the month preceding the triggering event, coverage Effective Date is the first day of the month in which the triggering event occurs. If the plan selection is made after the triggering event, coverage Effective Date is the first day of the following month; or
- In the case of untimely notice of a triggering event, the exchange must provide the earliest Effective Date that would have been available based on the applicable triggering event.

For all other triggering events the Effective Date will be the first day of the following month.

Specific Causes for Ineligibility

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

- When Premiums are not paid according to the due dates and grace periods described in the Premium section.
- For the spouse - when the spouse is no longer married to the Policyholder.
- For You and Your Family Member(s) - when you no longer meet the requirements listed in the Eligibility Requirements section.

- The date the Policy terminates.
- When the Insured Person no longer lives in the Service Area.

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

Continuation

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 Healthcare and pays the appropriate monthly Premium within 60 days following the date this Policy would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

How the Policy Works

Note: Services performed by a Non-Participating (an Out-of-Network) Provider are not covered under this Policy except for Emergency Services and as shown in the section titled "Special Circumstances."

Benefit Schedule

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

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

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

Participating Hospitals, Participating Physicians and Other Participating Providers
Covered Expenses for services provided by Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to charge more than the Cigna Healthcare 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 Healthcare.

Special Circumstances

This Policy does not cover Charges 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 or of an independent freestanding emergency facility are paid as described in the benefit schedule. This includes coverage for additional out-of-network post-stabilization Covered Services as required by applicable federal law. 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 Provider are not covered, except as stated in the Other Circumstances section below.

- **Other Circumstances**
  Covered Expenses for 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:
  - Emergency Services.
  - Non-Emergency Services provided to an Insured Person at a participating facility if the non-Emergency Services involve surgical or ancillary services provided by a Non-Participating Provider.
  - Services for an Urgent Health Problem in an office, Urgent Care facility, or another outpatient facility and the Physician and other related Provider services.
  - Medically Necessary services that are not available from a Participating Provider.

  Note: if you are using a Non-Participating Provider for any of the reasons above, except for Emergency Services, please be aware that it is your responsibility to obtain any Prior Authorization required for services the Provider performs.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before this Policy will pay your claims. 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 the Allowed Expense, any penalties, or expenses that are not Covered Expenses.

Deductibles will be applied in the order in which an Insured Person's 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 this Policy will pay your claims. 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 Deductible, Copayment and Coinsurance each Family Member incurs in Covered Expenses 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 In-Network Covered Services, you will no longer have to pay any Coinsurance or Copayment for medical or Pharmacy services for Covered Expenses incurred In-Network 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 for In-Network Covered Services has been met, the Family Members will no longer have to pay any Deductible, Coinsurance or Copayments for Covered Expenses incurred In-Network 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.

Special Limits

There may be limits applied to certain Covered Services in the form of an Annual maximum on the number of visits, days or events the Policy will cover for a specific type of service. The expenses you incur which exceed specific maximums described in this Policy will be your responsibility. Any special limits applicable to benefits in this Policy are described in the benefit schedule.

The expenses you incur which exceed specific maximums described in this Policy will be your responsibility.

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 may 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 this Policy pays claims.

Comprehensive Benefits: What the Policy Pays For

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

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

Before this Policy pays for any benefits, You and Your Family Member(s) 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 Member(s) receive the service or supply for which the Charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the benefit schedule and subject to limits outlined in the section entitled "How the Policy Works."

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

Note: Services from an Out-of-Network (Non-Participating) Provider are not covered except for Emergency Services and as shown in the section titled "Special Circumstances."

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.

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

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

- Inpatient services and supplies provided by the Hospital except private room Charges above the prevailing two-bed room rate of the facility.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/therapeutic lab and x-rays.
- Anesthesia and inhalation therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

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

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

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. 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.

Hospice Care

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

To be eligible for this benefit, the Hospice Care Services Provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The Provider must also be approved as a Hospice Care Services Provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Policy is sold.

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

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

Professional and Other Services

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Virtual Care Services;
- Services of an anesthesiologist or an anesthetist;

- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products;
- Internal Prosthetic Appliances and Devices/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.

Durable Medical Equipment

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

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

Note: Medical equipment and supplies must meet all of the above requirements in order to be eligible for benefits under this 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 Healthcare 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 Healthcare 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 an Insured Person's misuse are the Insured Person's responsibility.

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.

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 (EKG's 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 for emergency situations to the nearest facility capable of handling the emergency.

This coverage includes Medically Necessary transport by air and/or water ambulance when:

- The point of pickup is not accessible by ground ambulance;
- Ground ambulance transport is not feasible due to the distance to the nearest Hospital capable of handling the patient's Illness or Injury or other obstacles to ground transport; or
- The time required for ground ambulance transport would impede timely and appropriate medical care.

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

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.

Coverage includes outpatient day rehabilitative services.

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.

Pulmonary and Cardiac 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.

Habilitative Services

This Policy provides benefits for Covered Expenses designed to assist you in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame and 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;
- Manipulation of the spine;
- Massage, to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury;
- 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.

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 "Exclusions and Limitations: What Is Not Covered by This Policy" 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, Applied Behavior Analysis 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.
- 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. This includes Methadone for the treatment of opioid use disorder (OUD) without Prior Authorization as part of an opioid treatment program.
- 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.

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 12 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.

Pregnancy and Maternity Care

Your 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 for a complicated or an uncomplicated pregnancy, miscarriage, or abortion. 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 "Who is Eligible for Coverage?"

Covered Services include:

- Professional and facility services for childbirth in a facility or the home, including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the Newborn during the mother's normal Hospital stay, including circumcision of a covered male dependent;
- Prenatal, postnatal, and postpartum services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us, and
- Abortions:
  - before 20 weeks of postfertilization if:
    - necessary to avoid death or serious health risk to the mother, or
    - diagnosis of fetal anomaly.
  - during the first 10 weeks postfertilization if:
    - pregnancy resulting from rape or incest.
  - at the earlier of viability or post 20 weeks postfertilization if:
    - necessary to avoid death or serious health risk to the mother.
  - necessary to save the life of the mother; and no other medical procedure will save the mother's life; and
  - necessary to prevent any serious risk to the mother; or necessary to save the mother's life.

The mother and her Newborn child are entitled, under federal law, to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a Provider obtain authorization for prescribing a length of stay that does not exceed the above periods. Any decision to shorten the period of inpatient care for the mother or the Newborn must be made by the attending Physician in consultation with the mother. If a decision is made between a mother and doctor to discharge a mother or Newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

Covered Services include two at-home post-delivery care visits provided by a Physician or nurse performed within 48 hours following you and your Newborn child's discharge from the Hospital. Coverage includes:

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your Newborn child, including the collection of an adequate sample for the hereditary and metabolic Newborn screening.

Note: You may choose to have this visit at the doctor's office.

In addition, the Policy provides coverage for an examination given to your Newborn child at the earliest feasible time for the detection of the following disorders:

- Phenylketonuria;
- Hypothyroidism;
- Hemoglobinopathies, including sickle cell anemia;
- Galactosemia;
- Maple Syrup urine disease;
- Homocystinuria;
- Inborn errors of metabolism that result in intellectual disability and that are designated by the state department of health;
- Physiologic hearing screening examination for the detection of hearing impairments;
- Congenital adrenal hyperplasia;
- Biotinidase deficiency;
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry;
- Spinal muscular atrophy;
- Severe combined immunodeficiency;
- Pulse oximetry screening examination at the earliest feasible time for the detection of low oxygen levels;
- Krabbe disease;
- Pompe disease;
- Hurler syndrome (MPS1);
- Adrenoleukodystrophy (ALD); and
- HIV or the antigen to HIV

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 wellness exams, including, but not limited to guidance and counseling regarding tobacco use, unhealthy alcohol use, unhealthy drug use, and obesity;
- Two Smoking Cessation Attempts; Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit;
- Screening for cervical cancer, colorectal cancer screening, routine hearing and vision screenings;
- Mammography includes coverage for the following: 1) if the Insured Person is at least 35 but less than 40, coverage for at least one baseline breast cancer screening mammography performed upon the Insured Person before she becomes 40 years of age; 2) if the Insured Person is less than 40 and a woman at risk, one breast cancer screening mammography performed every year; 3) if the Insured Person is at least 40, one breast cancer screening mammography performed every year; 4) Any additional mammography views that are required for proper evaluation; and 5) Ultrasound services, if determined Medically Necessary by the Physician treating the Insured Person.
- One Prostate specific antigen (PSA) test is covered annually for an Insured Person who is either at least 50 years of age or who is less than 50 years of age and high risk for prostate cancer;
- Colorectal cancer screenings for an Insured Person who is (1) at least 45 years old; or (2) less than 45 years old and at high risk for colorectal cancer,
- Evidence-based items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF);
- Immunizations 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 immunizations for travel (medications used for travel prophylaxis, except anti-malarial drugs), employment, school or sports.

Genetic Testing

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

- an Insured Person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that an Insured Person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- Genetic counseling is covered when covered genetic testing is under consideration or planned or if an Insured Person is at risk for an inherited disease or carrier state.

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 Healthcare 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 Healthcare 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.

Organ and Tissue Transplants and Related Specialty Care

Coverage is provided for human organ and tissue transplant services at any Cigna LifeSOURCE Designated Transplant Network® Facility throughout the United States. 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 deceased or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

NOTE: Most In-Network Provider facilities are NOT contracted to provide transplant services or NOT identified as a Cigna LifeSOURCE Designated Transplant Network® Facility. If you elect to have transplant services at an in-network facility that is not identified as Cigna LifeSOURCE Designated Transplant Network® Facility, those services would not be covered. For more information on whether an in-network facility is contracted with Cigna LifeSOURCE Designated Transplant Network® Facility to provide transplant services, contact your LifeSOURCE case manager or call 1-800-287-0539.

Transplant Travel Services

Coverage is provided for transportation and lodging expenses incurred by you in connection with a pre-approved organ/tissue transplant that if reimbursed by Cigna Healthcare 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 Cigna LifeSOURCE Designated 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.

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, Diabetic Equipment and Diabetic Pharmaceuticals and Supplies for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus.

Foreign Country Providers

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

Cigna Healthcare does not accept assignment of benefits from Foreign Country Providers. You and Your Family Members can file a claim with Cigna Healthcare 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.

Home Health Care Services

This Policy includes benefits for Covered Expenses for home health services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility. Home health services are provided only if Cigna Healthcare has determined that the home is a medically appropriate setting.

Home health services are those skilled health care services that can be provided during visits by Other Health Care Professionals, including Medically Necessary services of a medical social worker. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by Providers in providing home health services are covered. Home health services do not include services by a person who is a member of Your family or Your dependent's family, or who normally resides in Your house or Your dependent's house even if that person is a Provider. Skilled nursing services or private duty nursing services provided in the home are subject to the home health services benefit terms, conditions and benefit limitations.

This Policy provides benefits for Covered Expenses for home health care prescribed by the Physician treating your condition when the following criteria is met:

- The care described in the plan of care must be for intermittent skilled nursing, or Physical, Occupational, and other short-term rehabilitative therapy services.
- The Insured Person must be confined at home, in lieu of hospitalization, under the active supervision of a Physician.
- The home health agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care.

The Physician must be treating the Illness or Injury that necessitates home health care. **Home health services are limited to any combined maximum number of visits each Year as shown in the benefit schedule**.

If the Insured Person is a minor or an adult who is dependent upon others for non-skilled care, Custodial Care and/or activities of daily living (e.g., bathing, eating, etc.), home health care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's non-skilled care and/or Custodial Care needs.

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:

- Prosthetic devices including:
    - Custom fabricated breast prostheses;
    - One additional breast prosthesis per breast affected by the mastectomy
- Reconstructive Surgery incident to the mastectomy including:
    - All stages of reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce symmetry;
    - Chest wall reconstruction, including aesthetic flat closure as defined by the National Cancer Institute

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.

Treatment for Temporomandibular/Craniomandibular Joint Dysfunction (TMJ)

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

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 include Prostheses/Prosthetic Appliances and Devices; Orthoses and Orthotic Devices; Braces; Splints; wigs; and surgical bras.

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.

- Only the following non-foot Orthoses are covered, when Medically Necessary:
  a. Rigid and semi-rigid custom fabricated Orthoses;
  b. Semi-rigid pre-fabricated and flexible Orthoses; and
  c. Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
- Custom foot Orthotics are only covered when Medically Necessary, as follows:
  a. For 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.

Clinical Trials

This Policy covers clinical costs and services related to an approved clinical trial for a qualified individual. The Insured Person must be eligible to participate according to the trial protocol and either of the following conditions must be met:

- the referring Physician is a Participating Provider and has concluded that the Insured Person's participation in such trial would be appropriate; or
- the Physician provides medical and scientific information establishing that the Insured Person's participation in the qualified trial would be appropriate.

In addition to qualifying as an Insured Person, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Benefits are limited to the following criteria:

- Federally funded trials approved or funded by one of the following:
- National Institutes of Health (NIH);
- Centers for Disease Control and Prevention (CDC);
- Agency for Health Care Research and Quality (AHRQ);
- Centers for Medicare and Medicaid Services (CMS);
- A cooperative group or center of any of the entities described above; or The Department of Defense (DOD) or the Department of Veterans Affairs (VA);
- A qualified non-governmental research entity identified in NIH guidelines for center support grants;
- Any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if both of the following conditions are met:
    - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
    - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The Policy does not cover the following:

- A service that is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of you;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for you, your family members or your companions that are associated with the travel to or from a Facility providing the approved clinical trial;
- A service provided by the clinical trial sponsors free of charge to you; and
- A service that is eligible for reimbursement by a person other than us, including the sponsor of the clinical trial.

Wellness and Other Program Benefits

Benefits may be available to You and Your Family Members for participating in certain programs that We may make available in connection with this Policy. Such programs may include wellness programs, disease or care management programs. These programs may include a reward or an incentive, which You may earn by completing different activities. You may obtain information regarding the particular programs available at any given time by visiting Our website at www.mycigna.com under “Wellness” then select “Wellness and Incentives,” or by calling the toll-free customer service number on the back of your ID card.

Off Label Drugs

This Policy provides benefits for Covered Expenses for off label use of a covered drug for a particular indication if:

- The drug is recognized for treatment of the indication in at least one (1) standard reference compendium and
- The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

Coverage does not include drugs which the FDA has determined off label use to be contraindicated, experimental drugs not approved for any indication by the FDA, and does not alter any other law limiting the coverage of drugs that have not been approved by the FDA.

Inherited Metabolic Disease

Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Chronic Pain Management

The plan provides benefits for Covered Services for chronic pain management for pain that:

- Continues after the healing of an Injury or the usual course of an acute Illness, and
- Significantly interferes with an Insured Person’s physical, vocational and psychosocial functioning.

Covered Services include:

- Medical supervision
- Physical and Occupational Therapy
- Medical management
- Prescription Drugs
- Guidance in relaxation techniques

Dental Anesthesia

Anesthesia and Hospital charges for dental care, for an Insured Person less than 19 years of age or an Insured Person who is intellectual or physically disabled, are covered if the Insured Person requires dental treatment to be given in a Hospital or outpatient ambulatory surgical facility. The Indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Insured Person's condition under general anesthesia constitutes appropriate treatment. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ). Prior Authorization required for services.

Wearable Cardioverter Defibrillator

The Policy provides Medically Necessary coverage for wearable cardioverter defibrillators that:

- are worn externally on an Insured Persons' body;
- continually monitors and analyzes the Insured Person's heart rhythm; and
- delivers a shock to the heart when an abnormal heart rhythm is detected.

Biomarker Testing

This Policy provides benefits for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment when the test is supported by the following medical and scientific evidence:

- a labeled indication for a test approved or cleared by the FDA;
- an indicated test for a dug approved or cleared by the FDA;
- A warning or precaution on the label of a drug approved by the FDA;
- a national coverage determination made by CMS or a local determination made by a Medicare administrative contractor;
- nationally recognized clinical practice guidelines; or
- consensus statement.

Coverage of the biomarker testing will only be provided when it provides clinical utility because use of the test for the condition:

- is evidenced-based;
- is scientifically valid;
- informs a patients outcome and a providers clinical decision; and
- predominantly addresses the acute or chronic issue for which the test is being ordered.

Coverage will be provided in a way that limits disruptions in care, this includes limiting the number of biopsies and biospecimen samples.

NOTE REGARDING PRIOR AUTHORIZATION

If a Prior Authorization requirement applies, We would approve or deny a request not more than five (5) business days after the request in the case of nonurgent request or in not more than forty-eight (48) hours after the request in the case of an urgent request.

Exclusions and Limitations: What Is Not Covered by This Policy

Excluded Services

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

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 Investigational 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 **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
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 in Medicare** Part A, B, C or D, Cigna Healthcare will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna Healthcare would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician 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. **Private duty nursing** except when provided as part of the home health care services benefit in this Policy.
20. Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or Physical Therapy.**
21. 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 a Mental Health Disorder.
22. **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; acupuncture point injection therapy; 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.
23. 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.
24. **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.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
26. 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.
27. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.

28. 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.
29. **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.
30. **Orthodontic services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
31. **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.
32. 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.
33. **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.
34. **Routine hearing tests** except as provided under Preventive Care.
35. **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 Care.
36. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).
37. **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.
38. **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 except as specifically stated in this Policy.
39. **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.
40. Services and procedures for **redundant skin surgery** including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia, varicose veins, rhinoplasty, blepharoplasty and orthognathic surgeries**.**

41. Procedures, surgery or treatments to **change characteristics of the body** to those of the opposite sex unless such services are deemed Medically Necessary or otherwise meet applicable coverage requirements.
42. Any treatment, Prescription Drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
43. All services related to **the 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), except as specifically stated in this Policy.
44. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
45. 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.
46. Blood administration **for the purpose of general improvement in physical condition.**
47. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot Orthotic Devices.
48. **External and internal power enhancements** or power controls for Prosthetic limbs and terminal devices.
49. **Myoelectric Prostheses** peripheral nerve stimulators.
50. **Electronic Prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
51. **Prefabricated foot Orthoses**.
52. **Cranial banding/cranial Orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
53. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
54. **Orthoses primarily used for cosmetic** rather than functional reasons.
55. **Non-foot Orthoses**, except **only** the following non-foot Orthoses are covered when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;
    - Semi-rigid pre-fabricated and flexible Orthoses; and
    - Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
56. 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.

57. **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.
58. 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.
59. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna Healthcare.
60. **Nutritional counseling or food supplements**, except as stated in this Policy.
61. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the "Comprehensive Benefits: What the Policy Pays For" 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; 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.
62. **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 Services (Physical Therapy, Occupational Therapy and Speech Therapy)" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."
63. **Foreign Country Provider** charges except as specifically stated under "Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits: What the Policy Pays For."
64. **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, a systemic condition, Injury or symptoms involving the feet except as otherwise stated in this Policy.
65. **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.
66. Charges for the **services of a standby Physician**.
67. Charges for **animal to human organ transplants**.
68. **Claims received by Cigna Healthcare after 15 months from the date service was rendered**, except in the event of a legal incapacity.
69. Services obtained from a **Dedicated Virtual Care Physician** that are not Dedicated Virtual Urgent Care or Dedicated Virtual Primary Care services.
70. Abortions, except in cases of rape, incest, lethal fetal anomaly, or when the pregnant person's life faces a serious health risk.

Prescription Drug Benefits

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 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 Healthcare'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-lists**.**

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 Brand Copayment 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 Healthcare'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.

Cigna Healthcare's Specialty Pharmacy

Accredo, Cigna Healthcare's specialty Pharmacy, is available to fill and ship Specialty Medications used to treat complex conditions. Accredo's team of specialty-trained pharmacists and nurses provide personalized care and support to manage your therapy.

When you use Cigna Healthcare's specialty Pharmacy for your Specialty Medications, you receive personalized care and support such as: 24/7 access to pharmacists and nurses with experience and training in complex conditions, counseling, help managing side effects and one-on-one guidance from a clinician on how to administer your Specialty Medication. Some Specialty Medications may be eligible for copay assistance programs for which a dedicated team can assist you. The specialty Pharmacy also allows you several choices on how you want to connect with them – by text, phone and/or online resources.

The specialty Pharmacy makes it convenient for you to get your Specialty Medications by working with your Physician to obtain Prior Authorization, if required. They also schedule and ship your Specialty Medications quickly and with special handling, such as refrigeration. All necessary supplies, such as syringes or a sharps container, are also included at no extra cost.

To make sure you don't miss any doses of your Specialty Medication they will send you refill reminders and real-time updates once your medication has shipped.

You or your Physician can call Accredo, Cigna Healthcare's specialty Pharmacy, at 877-826-7657 to talk with a representative.

Prescription Drugs Covered under the Medical Benefits

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

Limited Distribution Drugs

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 Accredo, Cigna Healthcare's preferred specialty Pharmacy, or if not available through Accredo then through a network specialty Pharmacy, in order for that drug to be covered. If you have questions about where your Provider obtained 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, on Cigna Healthcare's Prescription Drug List are covered under the Prescription Drug benefits of this Policy. To determine if a drug prescribed for you is covered, you can:

- log on to your www.mycigna.com account, and
- view the Cigna Healthcare Prescription Drug List at www.cigna.com/ifp-drug-lists, and
- then choose the Cigna Healthcare 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 Healthcare's Prescription Drug List are covered under the medical benefits of this Policy when they 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 Healthcare Prescription Drug List by:

- accessing www.cigna.com/ifp-drug-lists, and
- choose your state.

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

Prescription Drug List Management

The Prescription Drug List is managed by the Health Plan Value Assessment Committee (HVAC), 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 Supply 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.

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 Healthcare 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 Healthcare 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 Healthcare 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 Healthcare directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna Healthcare 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 Healthcare 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 Healthcare 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 a 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 Healthcare 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 Healthcare 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 Healthcare 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 Healthcare 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 Customer Service at the telephone number on your ID card.

EnReach Rx Program

This Policy provides coverage for specific glucagon-like peptide 1 (GLP-1) medications to treat type 2 diabetes upon Prior Authorization. The EnReach Rx Program offers enhanced clinical and customer support at point-of-service when using a Pharmacy that participates in the EnReach Rx Program. Participating In-Network pharmacies include both retail pharmacies and Evernorth EnGuide Home Delivery Pharmacy. More information on the EnReach Rx Program is available by calling Customer Service at the telephone number on your ID card.

What Is Covered

- Outpatient drugs and medications that federal and/or applicable state law restrict to sale by Prescription only, except for insulin which does not require a Prescription.
- Pharmaceuticals to aid smoking cessation in accordance with “A” or “B” recommendations of the U.S. Preventive Services Task Force.
- Insulin (no Prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon Emergency Kits and alcohol swabs.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescription Drugs that contain at least one FDA-approved Prescription ingredient compounded from an FDA-approved finished pharmaceutical product and are otherwise covered under the Pharmacy benefits, excluding any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA.
- 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 Participating 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 Express Scripts Pharmacy, or Evernorth EnGuide Pharmacy, Cigna Healthcare’s home delivery pharmacies.
- 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.

Exclusions

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

1. Drugs not approved by the Food and Drug Administration;
2. Any drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process;
3. 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);
4. Drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
5. Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
6. 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;
7. 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;
8. Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
9. 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;
10. 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;
11. Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
12. 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”;
13. 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 biomedical journals;
14. Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment;
15. 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);
16. 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;

17. Medications used for travel prophylaxis, except anti-malarial drugs;
18. Drugs obtained outside the United States;
19. Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
20. Drugs used to enhance athletic performance;
21. 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. Coverage for these Drugs is stated within the Policy under the "Comprehensive Benefits: What the Policy Pays For" section;
22. 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. Coverage for these Drugs, medications, or other substances is stated within the Policy under the "Comprehensive Benefits: What the Policy Pays For" section;
23. Drug convenience kits;
24. Prescriptions more than one year from the original date of issue;
25. Any costs related to the mailing, sending or delivery of Prescription Drugs;
26. Any intentional misuse of this benefit, including Prescription Drugs and Related Supplies purchased for consumption by someone other than the Insured Person.

Limitations

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

- Up to a 30-day supply, at a retail Participating Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the benefit schedule).
- 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 benefit schedule).
- Up to a 90-day supply at Express Scripts Pharmacy, or Evernorth EnGuide Pharmacy, Cigna Healthcare's home delivery pharmacies for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the benefit schedule).
- Tobacco cessation medications that are included on Cigna Healthcare'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 Related Supplies. This means you will pay 100% of the discounted cost, rather than the full cost, of Prescription Drugs and Related 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.

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

Authorization from Cigna Healthcare is required for certain Prescription Drugs and Related Supplies, meaning that your Physician must obtain Authorization from Cigna Healthcare 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 Healthcare requires your Physician to obtain Authorization before the Prescription or supply can be filled. To obtain Prior Authorization, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy
Step Therapy is a type of Prior Authorization. Cigna Healthcare 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 try one or more similar Prescription Drugs and Related Supplies before the Policy will cover the requested Prescription Drug or Related Supply. 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 Healthcare's Prescription Drug List, he or she can request that Cigna Healthcare 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 Healthcare, or complete the appropriate form and fax it to Cigna Healthcare 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 Healthcare'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 Healthcare 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 Healthcare's Prescription Drug List. The expedited review will be reviewed and completed by Cigna Healthcare within 24 hours of receipt.

If the request is approved, your Physician will receive confirmation. The Authorization/Exception will be processed in Cigna Healthcare'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 or your Physician requested a drug that is not on the Prescription Drug List, you have the right to appeal the initial coverage decision directly to an Independent Review Organization (IRO) without going through Cigna Healthcare's appeals process. Please see the "When You Have a Complaint or an Appeal" section for more information.

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

Coverage of New Drugs

All new 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 Health Plan Value Assessment Committee (HVAC) 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 Health Plan Value Assessment Committee (HVAC) 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.

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 benefit 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, or Evernorth EnGuide Pharmacy, Cigna Healthcare's home delivery pharmacies, see the home delivery drug brochure at 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 Healthcare Pharmacy Service Center
PO Box 188061
Chattanooga TN 37422-8061

For home delivery Pharmacy claims:

Express Scripts Pharmacy
PO Box 66301
St Louis MO 66301-6301
1-800-835-3784

Evernorth EnGuide Pharmacy
PO Box 66500
St. Louis MO 63166-6500
1-800-835-3784

Forms are also available online at www.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 your ID card to confirm the appropriate mailing address for any claim form you wish to send. If You or Your Family Member(s) have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of your ID card**.**

Pediatric Vision Care

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 the limiting age is reached.

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

Covered Services

Covered Services for an Insured Person, 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 include all prescriptions 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:
  - Oversize lenses
  - All solid and gradient tints
  - Scratch-coating
  - Ultraviolet (UV) coating
  - Additional savings* on all lens enhancements you choose for your lenses, including but not limited to: anti-reflective coatings; polarized; high-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 Year from pediatric frame collection. Only frames in the pediatric frame collection are covered at 100%; there is a one-year manufacturer warranty for standard frames. The Cost Share for non-covered frames is up to 80% of retail.
- Elective contact lenses – One pair of conventional or one box of disposable contact lenses per eye, including professional services, in lieu of lenses and frame benefit (may not receive contact lenses and frames in the same benefit Year).
- Therapeutic contact lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. Coverage for therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; 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 but will be covered in accordance with the Elective contact lens benefit shown in the Benefit Schedule.

- Low vision coverage – Supplemental professional low vision services and aids are covered in full once every 12 months 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.

Exclusions

1. Services not provided by a Cigna Vision In-Network Provider.
2. Orthoptic or vision training and any associated supplemental testing.
3. Medical or surgical treatment of the eyes.
4. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
5. Any Injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
6. Charges in excess of the U&C charge for the service or material.
7. Charges incurred after the Policy ends or your coverage under the Policy ends, except as stated in the Policy.
8. Experimental or non-conventional treatment or device.
9. Magnification or low vision services and aids not otherwise listed in "Covered Services" within this section, above.
10. Any non-prescription eyeglasses, lenses, or contact lenses.
11. Spectacle lenses, treatments, add-ons, or lens coatings not otherwise listed in "Covered Services" within this section, above.
12. Two pairs of glasses, in lieu of bifocals or trifocals.
13. Safety glasses or lenses required for employment.
14. VDT (video display terminal)/computer eyeglass benefit.
15. For or in connection with Experimental Procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
16. Claims submitted and received in excess of twelve (12) months from the original date of service.
17. Services provided out-of-network without Cigna Vision's prior approval are not covered.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Insured Person should visit www.mycigna.com and use the link on the vision coverage page, or if You or Your Family Member(s) have any questions about the pediatric vision benefit, call the toll-free customer service number on the back of your ID card.

General Provisions

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.

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

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

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

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

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

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

If the benefits for a Covered Expense under your Primary Plan are reduced because you did not comply with the Primary Plan's requirements (for example, getting pre-certification of 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 Covered Expenses 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 Covered Expenses is the Allowable Expense less the amount paid by the Primary Plan during a Claim Determination Period.

If while covered under this plan, you are also covered by another Cigna Healthcare individual or group plan, you will be entitled to the benefits of only one plan. You may choose this plan or the plan under which you will be covered. Cigna Healthcare 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 Healthcare under the plan you elected to cancel will be deducted from any such refund of Premium.

Recovery of Excess Benefits
If this plan is the Secondary Plan and Cigna Healthcare pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna Healthcare pays any amount in excess of what it is obligated to pay, Cigna Healthcare will have the right to recover the actual overpayment made. Cigna Healthcare 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 Healthcare, 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 55 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Enrollment

If an Insured Person is enrolled in Medicare, Cigna Healthcare 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 Healthcare 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 Healthcare’s Negotiated Rate for a Participating Provider; or
- Cigna Healthcare’s Allowed Expense for a Non-Participating Provider.

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to the Insured Person also refers to a representative or Provider designated by an Insured Person 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 help. If an Insured Person has a concern regarding a person, a service, the quality of care, or 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 an Insured Person is not satisfied with the results of a coverage decision, they can start the appeals procedure.

If the Prescription Drug you request is not on the Prescription Drug List, you also have the right to pursue an independent external review without going through Cigna Healthcare's appeal process.

Appeals Procedure

Cigna Healthcare has a single level internal appeals procedure for coverage decisions. To initiate an appeal for most claims, the Insured Person must submit a request for an appeal within 365 days of receipt of a denial notice. If the Insured Person appeals a reduction or termination in coverage for an ongoing course of treatment that We previously approved, the Insured Person will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

The Insured Person should state the reason why he or she feels the appeal should be approved and include any information supporting the appeal. If an Insured Person is unable or chooses not to write, he or she may ask to register the appeal by telephone. Call Us at the toll-free number on your benefit identification card, explanation of benefits or claim form.

Most requests for review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessary or clinical appropriateness, the Committee will consult with at least one Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna Healthcare's Physician Reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge receipt of the appeal within 5 business days of the date We receive it and schedule a Committee review. Our acknowledgment may be given orally or in writing. 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 20 business days after We receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, We will notify the Insured Person in writing to request an extension of up to 15 calendar days for a pre-service or concurrent appeal and 10 calendar days for a post-service coverage determination and to specify any additional information needed to complete the review.

The Insured Person's appeal will be resolved as expeditiously as possible, reflecting the clinical urgency of the situation.

If you or your Physician requested a drug that is not on the Prescription Drug List, you have the right to appeal the initial coverage decision or any subsequent coverage decisions directly related to an IRO. The IRO will respond within 72 hours for standard requests.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna Healthcare in connection with the appeal, Cigna Healthcare 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 Us, We 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 Committee's decision within the time frames above.

The Insured Person may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause the Insured Person severe pain which cannot be managed without the requested services; or the Insured Person's appeal involves non-authorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, We will respond orally with a decision within 48 hours, after the appeal is initiated and all necessary information to complete the appeal is reviewed, followed up in writing within 2 calendar days of the decision.

If you or your Physician requested a drug that is not on the Prescription Drug List and you meet the criteria above, you may request an expedited external review of the initial coverage decision or any subsequent coverage decisions.

If the Insured Person is not fully satisfied with the decision of Cigna Healthcare's appeal review regarding his or her Medical Necessary, clinical appropriateness issue, or a determination that a proposed service is Experimental or Investigational the Insured Person may request that his or her appeal be referred to an Independent Review Organization.

If you or your Physician requested a drug that is not on the Prescription Drug List, you have the right to appeal the initial coverage decision or any subsequent coverage decisions directly to an IRO. The IRO will respond within 24 hours for expedited requests.

Independent Review Procedure (External Grievance)

The Independent Review Organization is composed of persons who are not employed by Cigna Healthcare or any of its affiliates.

There is no charge for the Insured Person to initiate this independent review process. Cigna Healthcare 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 determination by Cigna Healthcare of Medical Necessary, clinical appropriateness or a determination that a proposed service is Experimental or Investigational. You may also request a referral to an IRO if You or your Physician requested a drug that is not on the Prescription Drug List. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, the Insured Person must notify the Appeals Coordinator within 120 days of his or her receipt of Cigna Healthcare's appeal review denial. Cigna Healthcare will then forward the file to the Independent Review Organization.

The Independent Review Organization will render a decision within 15 business days. When requested and when a delay would jeopardize his or her life or health or the ability to reach and maintain maximum function, as determined by Cigna Healthcare's Physician Reviewer, the review shall be completed within 72 hours. The Independent Review Program is a voluntary program.

Assistance from the State of Indiana

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

Consumer Services Division
Indiana Department of Insurance
311 West Washington, Suite 300
Indianapolis IN 46204-2787
Consumer Hotline: 317-232-2395 or 1-800-622-4461

Complaints can be filed electronically at http://www.in.gov/idoi/3008.htm

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 denial decision; (3) reference to the specific Policy provisions on which the decision 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 Necessary, 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. 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 (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 Policy 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.

Terms of the Policy

- **Entire Contract:**
  This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an officer of Cigna Healthcare 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.

- **Class Action Waiver:**
  Without limiting any applicable state law, You (including any legal representative acting on Your behalf) expressly waive the right to participate, as a plaintiff or class member, in any purported class, collective, representative, multiple plaintiff or similar proceeding (Class Action). Except as provided by any applicable state law; under this provision of the Policy You expressly waive the ability to maintain a Class Action in any forum.

- **Grace Period:**
  You must remit the amounts specified by Cigna Healthcare, to Cigna Healthcare, 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 10 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 3 consecutive months during which the Premiums may be paid without loss of coverage. Coverage will continue during the grace period. However, if We do not receive Your Premium within the grace period, Your coverage will be terminated as of the last day of the first month during the grace period if APTCs are received.

We will continue to pay all appropriate claims for Covered Services rendered to the Insured Person during the first month of the grace period, and We will not pay claims for Covered Services rendered to the Insured Person in the second and third month of the grace period unless and until the Premium is paid. We will notify Health and Human Services (HHS) of the non-payment of Premiums, the Insured Person, as well as Providers of the possibility of denied claims when the Insured Person is in the second and third month of the grace period. We will continue to collect APTC on behalf of the Insured Person from the Department of the Treasury, and will return the APTC on behalf of the Insured Person for the second and third month of the grace period if the Insured Person exhausts their grace period as described above. An Insured Person is not eligible to re-enroll once terminated, unless the Insured Person has a special enrollment period or during the Annual Open Enrollment period.

Please see the provisions titled “Cancellation” and “Reinstatement” for further information regarding cancellation and reinstatement. In no event shall Cigna Healthcare 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 Healthcare shall be entitled to health care services hereunder, and then only for the period for which payment is received.

- **Cancellation:**
  We may cancel this Policy at midnight on the date of any of the following events:
  1. You fail to pay Your Premiums as they become due or by the end of the last day of the 10 day grace period for plans not purchased from a Marketplace or the 3 consecutive month grace period for plans purchased from a Marketplace.
  2. On the first of the month following Our receipt of Your written notice to cancel.
  3. When You become ineligible for this coverage.
  4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Policy or coverage.
  5. When We cease to offer policies of this type to all individuals in Your class. In this event, Indiana 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 Indiana, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
  7. When the Policyholder no longer lives in the Service Area.

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

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

- **Modification of Coverage:**
  We reserve the right to modify this Policy, including Policy provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled Premium due date thereafter. Payment of the Premiums will indicate acceptance of the change.

- **Reinstatement:**
  If the renewal Premium is not paid before the grace period ends, the Policy will lapse. Later acceptance of the Premium by the insurer, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this Policy. If the insurer or its agent requires an application, the Insured Person will be given a conditional receipt for the Premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 45th day after the date of the conditional receipt unless the insurer has previously written the Insured Person of its disapproval. The reinstated Policy will cover only loss that results from an Injury sustained after the date of reinstatement or sickness that starts more than 10 days after such date. In all other respects, the rights of the Insured Person and the insurer will remain the same, subject to any provisions noted on or attached to the reinstated Policy. Any Premiums the insurer accepts for a reinstatement will be applied to a period for which Premiums have not been paid. No Premiums will be applied to any period more than 60 days before the reinstatement date.

- **Renewal:**
  This Policy renews on a Calendar Year basis.

- **Fraud:**
  If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect. 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 Healthcare 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 Healthcare 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:**
  You cannot file a lawsuit before 60 days after We have been given written proof of loss in accordance with the requirements of this Policy. No action can be brought after 3 years from the time that proof is required to be given.

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

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

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

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

- **Identification cards** issued by Cigna Healthcare 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 Healthcare and Participating Providers** who are not employees of Cigna Healthcare are independent contractor relationships. Such Participating Providers are not agents or employees of Cigna Healthcare; and Cigna Healthcare and its employees are not agents or employees of such Participating Providers. Cigna Healthcare 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 Healthcare 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 Healthcare
Individual Services
PO Box 30028
Tampa FL 33630-3028

- **When the amount paid by Cigna Healthcare 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 Healthcare.

- **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 Member(s), You or Your Family Member(s) 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 an Emergency Medical Condition**, 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 Healthcare 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 Healthcare determines that You or Your Family Member(s) may be materially and adversely affected.

- **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 Healthcare 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 Healthcare 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 Healthcare 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 Healthcare reserves the right 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 legislative act.

- **Physical Examination and Autopsy:** Cigna Healthcare, 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 Healthcare shall have the right and opportunity to make an autopsy where it is not prohibited by law.

- **Change of Beneficiary**: Unless You make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to You and the consent of any other beneficiary shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

Other Insurance with This Insurer

If while covered under this Policy, the Insured Person(s) is also covered by another Cigna Healthcare 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 Healthcare will then refund any Premium received under the other policy covering the time period both policies were in effect.

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

How to File a Claim for Benefits

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

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

Claim Forms: You may get the required claim forms from www.cigna.com under Health Care Providers, Coverage and Claims, or by calling Customer Service using the toll-free number on your identification card. Cigna Healthcare must provide you with claim forms within 15 days.

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

If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna Healthcare CLAIM OFFICE.
  - YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
  - YOUR GROUP NUMBER IS THE 8-DIGIT 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 as described above. Canceled checks or receipts are not acceptable. Cigna Healthcare 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 Healthcare's contracts with Providers, all claims from contracted Providers should be assigned.

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

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to 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 assume no responsibility for the validity or effect of an assignment.

Timely Payment of Claims: Benefits will be paid immediately upon receipt of due written proof of loss.

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 for non-Emergency Services performed by a Non-Participating Provider at a Participating facility, Emergency Services provided by a Non-Participating Provider, and air ambulance services provided by a Non-Participating Provider will be paid directly to the Non-Participating Provider. Any other 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.

Claim Determination Procedures Under Federal Law

(Provisions of the laws of this state may supersede.)

Procedures Regarding Medical Necessity Determinations

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

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

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

Pre-service Medical Necessity Determinations
When the Insured Person or their representative requests a required medical necessity determination prior to care, Cigna Healthcare 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 Healthcare's control, Cigna Healthcare will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Us within 45 days after receiving the notice. The determination period will be suspended on the date Cigna Healthcare 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 Healthcare will make the pre-service determination on an expedited basis. Cigna Healthcare's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna Healthcare 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 Healthcare 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 Us within 48 hours after receiving the notice. Cigna Healthcare 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 Healthcare's procedures for requesting a required pre-service medical necessity determination, Cigna Healthcare 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 Healthcare 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 Healthcare 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 Our control, We will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

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

Premiums

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

You will be responsible for an additional $5.25 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 charges incurred by You are received by Cigna Healthcare.

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 Healthcare 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 Healthcare 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 Healthcare in writing. Cigna Healthcare 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.

Cigna HealthCare will refund any unused Premiums upon the death of the Policyholder during the Annual Calendar Year.

Upon the payment of a claim under this Policy, any Premium that is due and unpaid or covered by any note or written order many be deducted therefrom.

Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422, 877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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 **https://www.hhs.gov/civil-rights/filing-a- complaint/complaint-process/index.html**

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Cigna Dental Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., and Cigna HealthCare of Texas, Inc. In Texas, the Dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO Advantage network. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al numero 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).

824707b 5/25 © 2025 Cigna Healthcare.

Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: 711 اطلب) أو تحدث إلى مقدم الخدمة الخاص بك.

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero
1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - توجه: همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید