Filing at a Glance

Company:	Cigna Health and Life Insurance Company
Product Name:	Medical Individual
State:	Tennessee
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Filing Type:	Form/Rate
Date Submitted:	04/29/2013
SERFF Tr Num:	CCGH-129001002
SERFF Status:	Closed-Approved
State Tr Num:	H-130551
State Status:	Approved
Co Tr Num:	67369
Implementation Date Requested:	01/01/2014
Author(s):	Janet Stone, Jennifer Linstone, Maria Mahmood
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt, Art Lucker
Disposition Date:	07/30/2013
Disposition Status:	Approved
Implementation Date:	01/01/2014

State Filing Description:
I HIX P
INDTNCH042013
individual health insurance exchange plans

General Information

Project Name: Form and Rate Filing 1/1/2014
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Maria Mahmood

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 07/30/2013
State Status Changed: 07/30/2013
Created By: Maria Mahmood
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: on and off exchange

Filing Description:

Cigna Health and Life Insurance Company
NAIC Company ID#: 67369
Forms and Rate Filing for Individual Health Plans
INDTNCH042013 – Effective 01/01/2014

We wish to market the following plans:

BRONZE
myCigna Health Savings 6100
myCigna Health Flex 5500

SILVER
myCigna Health Savings 3400
myCigna Health Flex 5000
myCigna Health Flex 1500

GOLD
myCigna Health Savings 1900
myCigna Health Flex 1250

We certify that the health benefit plan's prescription drug benefit complies with the final rule on Standards Related to Essential Health Benefit, Actuarial Value, and Accreditation and the list of drugs covered.

Company and Contact

Filing Contact Information

Maria Mahmood, Compliance Specialist
900 Cottage Grove Road
Hartford, CT 06152

maria.mahmood@cigna.com
860-226-5080 [Phone]
860-226-3183 [FAX]

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Filing Company Information

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, CT 06002
(860) 226-6000 ext. [Phone]

CoCode: 67369
Group Code: 901
Group Name:
FEIN Number: 59-1031071

State of Domicile: Connecticut
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Vicky Stotzer	07/29/2013	07/30/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Company Response	Melissa Merritt	07/08/2013	07/08/2013
Pending Company Response	Art Lucker	06/30/2013	06/30/2013
Pending Company Response	Melissa Merritt	05/30/2013	05/30/2013
Pending Company Response	Melissa Merritt	05/13/2013	05/13/2013

Response Letters

Responded By	Created On	Date Submitted
Janet Stone	07/12/2013	07/12/2013
Maria Mahmood	07/12/2013	07/12/2013
Maria Mahmood	06/14/2013	06/18/2013
Maria Mahmood	05/15/2013	05/16/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	INDTNCH042013	Janet Stone	07/25/2013	07/25/2013
Supporting Document	Redline Policy 7-23-13	Janet Stone	07/25/2013	07/25/2013

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Comment 2	Note To Filer	Vicky Stotzer	07/11/2013	07/11/2013
Dear Ms Merritt	Note To Reviewer	Janet Stone	07/09/2013	07/09/2013
HSA	Note To Filer	Vicky Stotzer	06/03/2013	06/03/2013
Regarding your letter	Note To Reviewer	Janet Stone	06/03/2013	06/03/2013
Thanks for the reply	Note To Reviewer	Maria Mahmood	05/16/2013	05/16/2013
Copy of Letter	Note To Filer	Brian Hoffmeister	05/16/2013	05/16/2013
Copy of Letter Request	Note To Reviewer	Maria Mahmood	05/16/2013	05/16/2013
Service Area	Note To Filer	Vicky Stotzer	05/15/2013	05/15/2013

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Disposition

Disposition Date: 07/30/2013
Implementation Date: 01/01/2014
Status: Approved

HHS Status: HHS Approved
State Review: Reviewed by Actuary

Comment:

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Cigna Health and Life Insurance Company	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Percent Change Approved:
Minimum: 0.000%
Maximum: 0.000%
Weighted Average: 0.000%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Accident & Health - Individual New Rates	Approved	Yes
Supporting Document	Actuarial Memorandum A & H Certification - Individual	Approved	Yes
Supporting Document	Cover Letter Accident & Health	Approved	Yes
Supporting Document	Description of Variables	Approved	Yes
Supporting Document	Filing Fees	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Third Party Authorization	Approved	Yes

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Readability Certification	Approved	Yes
Supporting Document	Consumer Disclosure Form	Approved	Yes
Supporting Document (revised)	Actuarial Memorandum and Certifications	Approved	Yes
Supporting Document	Actuarial Memorandum and Certifications	Replaced	Yes
Supporting Document (revised)	Unified Rate Review Template	Approved	Yes
Supporting Document	Unified Rate Review Template	Replaced	Yes
Supporting Document	Unique plan Design certification	Approved	Yes
Supporting Document (revised)	AVP inputs	Approved	Yes
Supporting Document	AVP inputs	Replaced	Yes
Supporting Document (revised)	Rating Business Rules	Approved	Yes
Supporting Document	Business Rules	Replaced	Yes
Supporting Document	Redlined Documents	Approved	Yes
Supporting Document	Plan Benefits	Approved	Yes
Supporting Document	Benefit Schedules	Approved	Yes
Supporting Document	Rate Response Letter	Approved	Yes
Supporting Document	Redline Policy 7-12-13	Approved	Yes
Supporting Document	Redline Policy 7-23-13	Approved	Yes
Form (revised)	INDTNCH042013	Approved	Yes
Form	INDTNCH042013	Replaced	Yes
Form	INDTNCH042013	Replaced	Yes
Form	INDTNCH042013	Replaced	Yes
Form (revised)	INDTNCHSPEC042013	Approved	Yes
Form	INDTNCHSPEC042013	Replaced	Yes

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	INDAPPTN0413	Approved	Yes
Rate (revised)	Rate pages	Approved	Yes
Rate	Rate pages	Replaced	Yes
Rate	Rate pages	Replaced	Yes

INS CONSULTANTS, INC.

Insurance Regulatory Consultants

419 S. 2nd Street
New Market, Suite 206
Philadelphia, PA 19147
Phone: (215) 625-9877
Fax: (215) 627-7104

TO: Vicky Stotzer
Health Analyst
Policy Analysis Section, Insurance Division
Tennessee Department of Commerce and Insurance

FROM: Mark Golab, FSA, MAAA
INS Consultants, Inc.

DATE: July 23, 2013

SUBJECT: Cigna Health and Life Insurance Company
Individual Health – PPO
SERFF Tracking Number: CCGH-129001002
TN Tracking Number: H-130551

INS Consultants, Inc. (INS) has reviewed the Individual PPO filing of Cigna Health and Life Insurance Company (CHLIC).

This is a new form filing that was submitted on June 18, 2013. The filing is not intended to replace any forms previously approved by the Tennessee DOI, and is subject to the requirements of Tennessee Regulations and the Affordable Care Act (ACA). The premium rates are to be effective from January 1, 2014.

After a review of the actuarial memorandum and Unified Rate Review Template (URRT) filed in support of the subject rate filing, INS identified on June 28, 2013 several matters that required additional clarification. On July 15, 2013, CHLIC provided clarification that responded, in part, to the questions raised by INS.

In support of their request, CHLIC has provided policy forms, a list of covered benefits, plan descriptions, premium rates, the Part 1 Unified Rate Review Template and a Part III Actuarial Memorandum The actuarial memorandum included, inter alia, actuarial assumptions, anticipated loss ratios, other information required by the ACA and appropriate actuarial certifications.

INS has reviewed the submission in its entirety. However, INS has given special consideration in its review to the details of the Company's Part III Actuarial Memorandum, the Part 1 Unified Rate Review Template and the characteristics of the rating elements subject to the Federal regulations

prescribed in 45CFR Part 147 paragraph 147.102. Based on that review, INS has come to the following key conclusions

URRT Section 1 Experience Period Data

- Since 2014 will be the first year that individual coverage will be offered by CHLIC in Tennessee, there is no experience period data to report in the URRT Worksheet 1, Section I.

URRT Section II Allowed Claims, PMPM Basis

- Since 2014 will be the first year that individual coverage will be offered by CHLIC in Tennessee, there is no allowed claims experience to report in the URRT Worksheet 1, Section II
- Benefit Category descriptions closely follow the preferred descriptions of the URRT instructions;

URRT Section II Credibility Manual

- The Company's credibility manual is predicated on national group experience adjusted for state and market specific differences. This baseline experience was adjusted by a 5% morbidity load, 1.04% demographic adjustment, a 0.2% load for the impact of EHB and a 4.4% decrement for network savings to recognize differences between the national group data and the anticipated individual market it 2014. Based on our review, the assumptions and methods relating to these adjustments appear actuarially reasonable.
- Based on our review of the CHLIC discussion and responses to our inquiries relating to the credibility manual, the credibility manual "utilization per 1,000" and "average cost/service" figures by benefit category appear actuarially reasonable.

URRT Section III Projected Experience

- The claims probability distribution methodology used to determine the "paid to allowed average factor in the projection period" of 71.6% is actuarially acceptable and such average factor is consistent with "paid to allowed" ratios at the plan level.
- The assumptions used to determine the "projected risk adjustments PMPM" of $0.00 are actuarially reasonable.
- The assumption and method used to determine the "projected ACA reinsurance recoveries, net of reinsurance premium, PMPM" of $28.81 appear reasonable and consistent with accepted actuarial practice.
- Administrative Expense Load, Profit and Risk Load, and Taxes and Fees appear reasonable for the individual market.
- The "index rate for projection period" of $380.58 is calculated as the 2014 allowed claims PMPM for the credibility adjusted pool (there are no benefits in excess of EHB for 2014).

Part III Actuarial Memorandum

- The Company's actuarial memorandum satisfies the Part III Actuarial Memorandum and Certification Instructions dated March 18, 2013 and issued by the Department of Health and Human Services.
- The company's calculation of the projected medical loss ratio (without adjustment for credibility) of 83.1% is actuarially reasonable.
- The company's methodology used to derive plan specific index rates is consistent with accepted actuarial methods.
- The Company's analysis and calculation of Actuarial Values were based entirely on the AV Calculator with the exception of three benefit designs. The AV for these three excepted benefit designs were calculated using an alternate methodology consistent with 45CFR 156.135(b).
- Regarding membership projections, the assumptions underlying the Company's expectation of membership enrollment appear actuarially reasonable.
- The Company has responded to the indicated "warning alerts"
- The actuarial memorandum includes the required actuarial certification.

Federal regulations prescribed in 45CFR Part 147 paragraph 147.102

- All premium rates vary only with respect to the allowable rating factors (1) family composition, (2) age, (3) tobacco use, and (4) geographic area.
- Relating to the family rating and in accordance with the subject Federal regulation, the premium calculation follows a member-level build up approach which is capped such that no more than the three oldest covered children under the age 21 can be taken into account when determining the total family premium.
- Relating to the premium age curve and in accordance with the subject Federal regulation, the premium variation between the youngest and the oldest adult individuals between the ages of 21-64 does not exceed a ratio of 3:1.
- Relating to the premium adjustment for tobacco use and in accordance with the subject Federal regulation, the premium rates vary by tobacco usage, but not by more than a 1.5:1 ratio.

Based on INS's review and on the certifying statements of CHLIC's opining actuary, INS suggests that the subject filing is compliant with Tennessee and PPACA regulations. Based on this conclusion, INS suggests that the submitted rate schedules are actuarially justified.

If you have any questions or would like additional information, please do not hesitate to call or e-mail.

_____

Mark Golab, FSA, MAAA

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	07/08/2013
Submitted Date	07/08/2013
Respond By Date	

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- INDTNCH042013, INDTNCH042013 (Form)

Comments: I will continue past the schedule and review this form but the schedules are too variable.

The office visit has "[$[0-250] Copayment] per office visit; [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250] Copay] [all visits after the first [1-10] per Year: [0-50]%

You can separate the variations that will be used but not run all the options together.

Objection 2

Comments: You need to correct the service area template in the binder. Is it pending with CMS?

Objection 3

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You need to put the real ranges benefits for the plans that you are filing. This includes the MOOP, deductibles, etc.

Objection 4

- Plan Benefits (Supporting Document)

Comments: There is no way to view this in the manner it is provided. the pages are not continued. Please provide an xls spreadsheet.

Objection 5

- INDTNCH042013, INDTNCH042013 (Form)

Comments: [The following do not accumulate to the Out-of-Network Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential Health Benefits,] [and] [Mental Health] [and] [Substance Abuse charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][Penalties] and Policy Maximums.]

This is also too variable. Which plans do these go with? How are these used.

Objection 6

- INDTNCH042013, INDTNCH042013 (Form)

Comments: Which plans don't cover preventive out of network?

Objection 7

- INDTNCH042013, INDTNCH042013 (Form)

Comments: In network pediatric dental and vision exams and diagnostics are considered preventive and must be covered at 100%, not subject to a deductible, coinsurance, or copayments. All other benefits may be subject to deductible, coinsurance, or

copayments.

Objection 8

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You have two familly and individual out of pocket definitions. They need to be combined. You have both coinsurance and copayments. You also need to add deductibles to these definitions.

Objection 9

- INDTNCH042013, INDTNCH042013 (Form)

Comments: In order to void the policy it must be an intentional material misstatement of fact, not just a material misstatement.

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,
Melissa Merritt

State:	Tennessee	**Filing Company:**	Cigna Health and Life Insurance Company
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)		
Product Name:	Medical Individual		
Project Name/Number:	Form and Rate Filing 1/1/2014/		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	06/30/2013
Submitted Date	06/30/2013
Respond By Date	07/12/2013

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- Actuarial Memorandum A & H Certification - Individual (Supporting Document)

Comments: Please provide the following information:

A. Credibility Manual Rate

1. Please show the development of the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

2 Regarding the adjustments made to the data, the actuarial memorandum states that a 5% load was added to the manual rate to account for the difference in morbidity risk of the population underlying the Manual Rate and the anticipated population of the Individual market in 2014. Please quantify the contributory effect that each of the following components has on the 5% morbidity load and please provide the actuarial basis for your quantification:

The influx of members from high-risk pools, HIPPA and conversion policies:

The influx of new entrants who were previously uninsured;

Plan selection;

Pent-up demand;

Non-Smoker population adjustment:

CSR plan induced utilization.

Additionally, please show how the 5%morbidity load is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

3. Regarding the demographic adjustment made to the data, please quantify the adjustment that was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2014 individual market. Please show how you developed this quantification. Additionally, please show how the demographic adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

4. Regarding the impact of EHB adjustment made to the data, please show how the 0.2% load for this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

5. Regarding the Network Savings adjustment made to the data, please show how the 5.2% decrement representing this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

B. Paid to Allowed Ratio

1 .Please demonstrate the development of the overall anticipated paid to allowed average factor of 71.6%

C. Risk Adjustment & Reinsurance

1. Please demonstrate the development of your estimate that ACA reinsurance recoveries net of reinsurance premiums will cover 12.5% of paid claims

D. Non Benefit Expenses and Profit and Risk

1. Please discuss how the percentage loads were allocated by product or plan

E. Projected Loss Ratio

1. Please reconcile the figures for incurred claims and earned premium shown in the demonstration of projected PPACA 2014 MLR with the corresponding 2014 projected figures shown in URRT worksheet 1, section III.

F. Index Rate

1. Please provide a description of the methodology used to adjust the index rate to arrive at each plan level rate based on the allowable adjustments outlined in 45CFR 156.80(d).

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,
Art Lucker

State:	Tennessee	**Filing Company:**	Cigna Health and Life Insurance Company
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)		
Product Name:	Medical Individual		
Project Name/Number:	Form and Rate Filing 1/1/2014/		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	05/30/2013
Submitted Date	05/30/2013
Respond By Date	

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

- INDTNCH042013, INDTNCH042013 (Form)

Comments: FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A [PENALTY][OR][LACK OF COVERAGE FOR THE SERVICES PROVIDED].

You can penalize but not deny coverage for failure to preauthorize.

Objection 2

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You cannot have a $25,000 deductible. The maximum for an individual is $6350 and for a family is $12,700. If this changes then you will need to refile the plan schedule with new rates.

Objection 3

Comments: Back to the schedule issue. I cannot review the binder and the forms at the same time. I cannot view the xlm or xlms files without conversion. These files are public record and must be viewable by the public.

We are allowing variablity in the numbers. Please remove all brackets from the language. We are not allowing variability in the language. I suggest you remove the schedule from the form and file separately. Attached is a sample pdf that can be done to allow variations in the schedule.

Objection 4

Comments: You are going to have to file separate policy forms for each product. PPO, EPO, HSA, etc.

Objection 5

Comments: Have you decided what you are going to do in Chattanooga? Expand or withdraw?

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Melissa Merritt

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Objection Letter

Objection Letter Status	Pending Company Response
Objection Letter Date	05/13/2013
Submitted Date	05/13/2013
Respond By Date	

Dear Maria Mahmood,

Introduction:

I have reviewed your filing and conclude the above referenced submission cannot be approved for use in the State of Tennessee for the following reasons:

Objection 1

Comments: Where are the schedules? Each plan must have a schedule.

Objection 2

- Rate pages, [INDTNCH042013] (Rate)

Comments: These pages must be magnified 400% to be read.

The rata data templates must be included in this filing, in a pdf format.

The benefit templates must be included in this filing in a pdf format.

The rate rule templates must be included in this filing in a pdf format.

Objection 3

Comments: Please note, these files are being reviewed for completeness and the forms have not been reviewed.

Conclusion:

It is unlawful, in accordance with Section 56-26-102, T.C.A. for you to utilize these forms and/or rates in Tennessee until you receive approval. This is a notice of disapproval. Your filing will be held in suspense for one hundred and twenty (120) days. If no response is received from you within this time period, your filing will be considered "disapproved" for the above stated reasons. If you have any questions, please phone Victoria Stotzer, primary reviewer, at (615) 741-6259 or through e-mail at victoria.stotzer@tn.gov.

Sincerely,

Melissa Merritt

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/12/2013
Submitted Date	07/12/2013

Dear Vicky Stotzer,

Introduction:

Dear Ms. Stotzer,

Response 1

Comments:

Benefit Schedule has been modified to remove any variables outside of the 2014 benefit plan offerings, and different plan options have been moved to separate lines.

Related Objection 1

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: I will continue past the schedule and review this form but the schedules are too variable.

The office visit has "[$[0-250] Copayment] per office visit; [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250] Copay] [all visits after the first [1-10] per Year: [0-50]%

You can separate the variations that will be used but not run all the options together.

Changed Items:

No Supporting Documents changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 2

Comments:

Per the filing note and reply this is resolved.

Related Objection 2

Comments: You need to correct the service area template in the binder. Is it pending with CMS?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

Variables have been edited to include only ranges within current 2014 plan offerings.

Related Objection 3

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You need to put the real ranges benefits for the plans that you are filing. This includes the MOOP, deductibles, etc.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 4

Comments:

Please find the document in xls format.

Related Objection 4

Applies To:

- Plan Benefits (Supporting Document)

Comments: There is no way to view this in the manner it is provided. the pages are not continued. Please provide an xls spreadsheet.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

All variables have been removed from this language which will be identical across all plans.

Related Objection 5

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: [The following do not accumulate to the Out-of-Network Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential Health Benefits,] [and] [Mental
Health] [and] [Substance Abuse charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][Penalties] and Policy Maximums.]

This is also too variable. Which plans do these go with? How are these used.

Changed Items:

No Supporting Documents changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 6

Comments:

All plans cover preventive services out-of-network. [Not Covered] variable has been removed.

Related Objection 6

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: Which plans don't cover preventive out of network?

Changed Items:

No Supporting Documents changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 7

Comments:

All variables have been removed In-network. Pediatric Dental and Vision are now showing only 0% Deductible waived in-network.

Related Objection 7

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: In network pediatric dental and vision exams and diagnostics are considered preventive and must be covered at 100%, not subject to a deductible, coinsurance, or copayments. All other benefits may be subject to deductible, coinsurance, or copayments.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 8

Comments:

Definitions are included for both Individual and Family / In-network and Out-of-network. We have kept them separate because of the references to Participating and Non-participating, since charges for covered expenses to not cross accumulate between In and out-of-network. Language has been added to each to show what charges (Copayments, Coinsurance, Deductibles) are included.

Related Objection 8

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You have two familly and individual out of pocket definitions. They need to be combined. You have both coinsurance and copayments. You also need to add deductibles to these definitions.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 9

Comments:

Terms of Policy / Time Limit on Certain Defenses, Page 62: except fraudulent misstatements has been edited to read except intentional, fraudulent misstatements. We also references intentional misstatements or misrepresentations on pages 1 (About This Policy), page 28 (Specific Causes for Ineligibility) and page 67 (Cancellation).

Related Objection 9

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: In order to void the policy it must be an intentional material misstatement of fact, not just a material misstatement.

Changed Items:

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Supporting Document Schedule Item Changes	
Satisfied - Item:	Benefit Schedules
Comments:	
Attachment(s):	Benefit Schedules.xls

Satisfied - Item:	Redline Policy 7-12-13
Comments:	
Attachment(s):	IND_TN_CH_Policy_071113_Redline.pdf

Supporting Document Schedule Item Changes	
Satisfied - Item:	Benefit Schedules
Comments:	
Attachment(s):	Benefit Schedules.xls

Satisfied - Item:	Redline Policy 7-12-13
Comments:	
Attachment(s):	IND_TN_CH_Policy_071113_Redline.pdf

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_071113_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*
2	INDTNCHSPEC042013	INDTNCHSPEC042013	POL	Initial		45.000	IND_TN_CH_Spec_062013_Clean.pdf	Date Submitted: 07/12/2013 By: Janet Stone
Previous Version								
2	*INDTNCHSPEC042013*	*INDTNCHSPEC042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Spec_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Conclusion:

Thank you very much for your review.

Sincerely,

Janet Stone

Sincerely,
Janet Stone

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/12/2013
Submitted Date	07/12/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

Please see attached response letter.

Related Objection 1

Applies To:

- *Actuarial Memorandum A & H Certification - Individual (Supporting Document)*

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Comments: Please provide the following information:

A. Credibility Manual Rate

1. Please show the development of the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

2 Regarding the adjustments made to the data, the actuarial memorandum states that a 5% load was added to the manual rate to account for the difference in morbidity risk of the population underlying the Manual Rate and the anticipated population of the Individual market in 2014. Please quantify the contributory effect that each of the following components has on the 5% morbidity load and please provide the actuarial basis for your quantification:
The influx of members from high-risk pools, HIPPA and conversion policies:
The influx of new entrants who were previously uninsured;
Plan selection;
Pent-up demand;
Non-Smoker population adjustment:
CSR plan induced utilization.
Additionally, please show how the 5%morbidity load is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

3. Regarding the demographic adjustment made to the data, please quantify the adjustment that was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2014 individual market. Please show how you developed this quantification. Additionally, please show how the demographic adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

4. Regarding the impact of EHB adjustment made to the data, please show how the 0.2% load for this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

5. Regarding the Network Savings adjustment made to the data, please show how the 5.2% decrement representing this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

B. Paid to Allowed Ratio

1 .Please demonstrate the development of the overall anticipated paid to allowed average factor of 71.6%

C. Risk Adjustment & Reinsurance

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

1. Please demonstrate the development of your estimate that ACA reinsurance recoveries net of reinsurance premiums will cover 12.5% of paid claims

D. Non Benefit Expenses and Profit and Risk

1. Please discuss how the percentage loads were allocated by product or plan

E. Projected Loss Ratio

1. Please reconcile the figures for incurred claims and earned premium shown in the demonstration of projected PPACA 2014 MLR with the corresponding 2014 projected figures shown in URRT worksheet 1, section III.

F. Index Rate

1. Please provide a description of the methodology used to adjust the index rate to arrive at each plan level rate based on the allowable adjustments outlined in 45CFR 156.80(d).

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rate Response Letter
Comments:	
Attachment(s):	Rate objection CCGH-129001002 Response.pdf

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Maria Mahmood

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/14/2013
Submitted Date	06/18/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

This has been changed to show that a penalty will be imposed but not a denial.

Related Objection 1

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A [PENALTY][OR][LACK OF COVERAGE FOR THE SERVICES PROVIDED].

You can penalize but not deny coverage for failure to preauthorize.

Changed Items:

No Supporting Documents changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_062013_Clean.pdf	Date Submitted: 06/18/2013 By: Maria Mahmood
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 2

Comments:

The schedule amounts are shown in the attachment called Benefit Schedules under Supporting Documentation. The variable amount shows a range targeted for future use, but not for use without approved rates.

Related Objection 2

Applies To:

- INDTNCH042013, INDTNCH042013 (Form)

Comments: You cannot have a $25,000 deductible. The maximum for an individual is $6350 and for a family is $12,700. If this changes then you will need to refile the plan schedule with new rates.

Changed Items:

No Supporting Documents changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_062013_Clean.pdf	Date Submitted: 06/18/2013 By: Maria Mahmood
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate/Rule Schedule items changed.

Response 3

Comments:

Variability has been omitted from the schedule. Also, benefit plan information has been added under Supporting Documentation in the document named Benefit Schedules.

Related Objection 3

Comments: Back to the schedule issue. I cannot review the binder and the forms at the same time. I cannot view the xlm or xlms files without conversion. These files are public record and must be viewable by the public.

We are allowing variablity in the numbers. Please remove all brackets from the language. We are not allowing variability in the language. I suggest you remove the schedule from the form and file separately. Attached is a sample pdf that can be done to allow variations in the schedule.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

As the HSA text consists of only two additional paragraphs you have allowed that small amount of variability in the Policy. The EPO text has been removed as we will not pursue that product at this time.

Related Objection 4

Comments: You are going to have to file separate policy forms for each product. PPO, EPO, HSA, etc.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments:

Please see revised rate pages, actuarial memorandum, unified rate review template, and AVPinputs files. Also, a post submission update will be done to revise the rate review detail section.

Related Objection 5

Comments: Have you decided what you are going to do in Chattanooga? Expand or withdraw?

Changed Items:

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	TN.Part3ActuarialMemorandum.06.13.13.99248.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*TN.Part3ActuarialMemorandum.04.22.2013.99248.pdf*

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	TN.UnifiedRateReviewSubmission.v1.6.pdf
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*TN.UnifiedRateReviewSubmission.v1.6.pdf*

Satisfied - Item:	AVP inputs
Comments:	
Attachment(s):	TN.AVCInputs.05.15.2013.99248.pdf
Previous Version	
Satisfied - Item:	*AVP inputs*
Comments:	
Attachment(s):	*TN.AVCInputs.04.22.2013.99248.pdf*

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	TN.Part3ActuarialMemorandum.06.13.13.99248.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*TN.Part3ActuarialMemorandum.04.22.2013.99248.pdf*

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	TN.UnifiedRateReviewSubmission.v1.6.pdf
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*TN.UnifiedRateReviewSubmission.v1.6.pdf*

Satisfied - Item:	AVP inputs
Comments:	
Attachment(s):	TN.AVCInputs.05.15.2013.99248.pdf
Previous Version	
Satisfied - Item:	*AVP inputs*
Comments:	
Attachment(s):	*TN.AVCInputs.04.22.2013.99248.pdf*

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	TN.Part3ActuarialMemorandum.06.13.13.99248.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum and Certifications*
Comments:	
Attachment(s):	*TN.Part3ActuarialMemorandum.04.22.2013.99248.pdf*

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	TN.UnifiedRateReviewSubmission.v1.6.pdf
Previous Version	
Satisfied - Item:	*Unified Rate Review Template*
Comments:	
Attachment(s):	*TN.UnifiedRateReviewSubmission.v1.6.pdf*

Satisfied - Item:	AVP inputs
Comments:	
Attachment(s):	TN.AVCInputs.05.15.2013.99248.pdf
Previous Version	
Satisfied - Item:	*AVP inputs*
Comments:	
Attachment(s):	*TN.AVCInputs.04.22.2013.99248.pdf*

No Form Schedule items changed.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate pages	INDTNCH042013	New		TN.RateTables.v2.2.pdf,	06/18/2013 By: Maria Mahmood
Previous Version						
1	*Rate pages*	*INDTNCH042013*	*New*		*TN.RateTables.v2.2.pdf,*	*05/16/2013 By: Maria Mahmood*
Previous Version						
1	*Rate pages*	*INDTNCH042013*	*New*		*TN.RateTables.v2.2.pdf,*	*04/29/2013 By: Maria Mahmood*

Conclusion:

Thank you for your review.

Sincerely,
Maria Mahmood

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/15/2013
Submitted Date	05/16/2013

Dear Vicky Stotzer,

Introduction:

Response 1

Comments:

Per my conversation with Ms Stotzer, the variable schedule in the policy shows the range from lowest to highest. Of course, those will be extracted when plans are prepared for each separate metal plan. The Plan and Benefit templates which show specific plan values are included in plan management filing CCGH-TN14-125000789.

Related Objection 1

Comments: Where are the schedules? Each plan must have a schedule.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

The rate pages were revised in an "easy to read" format. All rating areas are included (3, 4 and 6)

The rate data template in a pdf format is included in the rate/rule schedule tab, file name: "TN.RateTables.v2.2.pdf."

The benefit template in a pdf format is included in the supporting documentation tab, file name "TN.PlansBenefitsv1.31.04.24.2013.1.pdf"

The rate rule template was included in the supporting documentation tab- file name "TN.RatingBusinessRule.v1.5.pfd"

Related Objection 2

Applies To:

- Rate pages, [INDTNCH042013] (Rate)

Comments: These pages must be magnified 400% to be read.

The rata data templates must be included in this filing, in a pdf format.

The benefit templates must be included in this filing in a pdf format.

The rate rule templates must be included in this filing in a pdf format.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rating Business Rules
Comments:	
Attachment(s):	TN.RatingBusinessRules.v1.5.pdf
Previous Version	
Satisfied - Item:	*Business Rules*
Comments:	
Attachment(s):	*TN.RatingBusinessRules.v1.5.pdf*

Satisfied - Item:	Plan Benefits
Comments:	
Attachment(s):	TN.PlansBenefitsv1.31.04.24.2013.1.pdf

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Supporting Document Schedule Item Changes	
Satisfied - Item:	Rating Business Rules
Comments:	
Attachment(s):	TN.RatingBusinessRules.v1.5.pdf
Previous Version	
Satisfied - Item:	*Business Rules*
Comments:	
Attachment(s):	*TN.RatingBusinessRules.v1.5.pdf*

Satisfied - Item:	Plan Benefits
Comments:	
Attachment(s):	TN.PlansBenefitsv1.31.04.24.2013.1.pdf

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Rate pages	INDTNCH042013	New		TN.RateTables.v2.2.pdf,	05/16/2013 By: Maria Mahmood
Previous Version						
1	*Rate pages*	*INDTNCH042013*	*New*		*TN.RateTables.v2.2.pdf,*	*04/29/2013 By: Maria Mahmood*

Response 3

Comments:

Thanks for letting us know.

Related Objection 3

Comments: Please note, these files are being reviewed for completeness and the forms have not been reviewed.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Maria Mahmood

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Amendment Letter

Submitted Date: 07/25/2013
Comments:
Dear Ms. Stotzer:

Please find the updated Policy and redline which contain corrections as follows:

Hearing Aids – removed reference to “through age 18” and added “per ear” to align with QHP template. Pages 8, 38 and 46
Dental Care – removed reference to “under age 8” for anesthesia for dental procedures. Pages 11 and 37
Autism Spectrum Disorders – removed reference to “For insured persons under age 12 only”. Pages 12 and 38
Specific Causes for Ineligibility – removed language from this section because it was in conflict with the Guarantee Issue Requirement. Page 28

We apologize for the oversight and appreciate your continued review.

Sincerely,

Janet Stone
Changed Items:

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_072313_Clean.pdf	Date Submitted: 07/25/2013 By:
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_071113_Clean.pdf*	*Date Submitted: 07/12/2013 By: Janet Stone*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_062013_Clean.pdf*	*Date Submitted: 06/18/2013 By: Maria Mahmood*
Previous Version								
1	*INDTNCH042013*	*INDTNCH042013*	*POL*	*Initial*		*45.000*	*IND_TN_CH_Policy_042013_Clean.pdf*	*Date Submitted: 04/29/2013 By: Maria Mahmood*

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Redline Policy 7-23-13
Comments:	
Attachment(s):	IND_TN_CH_Policy_072313_Redline.pdf

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Filer

Created By:

Vicky Stotzer on 07/11/2013 08:59 AM

Last Edited By:

Vicky Stotzer

Submitted On:

07/11/2013 08:59 AM

Subject:

Comment 2

Comments:

Yes, that is fine.
Vicky

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Reviewer

Created By:

Janet Stone on 07/09/2013 02:24 PM

Last Edited By:

Janet Stone

Submitted On:

07/09/2013 02:24 PM

Subject:

Dear Ms Merritt

Comments:

We do not understand the discrepancy with the service area template. The most recent version we provided includes all of the counties in the Chattanooga Rating Area. It also has a dental service area included because CMS will only allow one template per issuer.

We validated the template and submitted it to CMS during our resubmission window. The resubmission was also validated. They are still reviewing our file, however we have filed a petition to change the template and CMS has acknowledged the petition.

Does this clarify for Objection #2? Thank you very much.

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Filer

Created By:

Vicky Stotzer on 06/03/2013 10:34 AM

Last Edited By:

Vicky Stotzer

Submitted On:

06/03/2013 10:34 AM

Subject:

HSA

Comments:

That can remain variable.

I also emailed the sample pdf.

Vicky

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Reviewer

Created By:

Janet Stone on 06/03/2013 10:02 AM

Last Edited By:

Janet Stone

Submitted On:

06/03/2013 10:03 AM

Subject:

Regarding your letter

Comments:

Dear Ms Merritt,

Thank you for your letter. We are preparing our documents for a reply.

Regarding Item #4, the only difference between and OAP plan and the HSA plan is the following text. We were hoping not to have to create a separate document. Would you be able to permit this small amout of variable text?

[About Health Savings Accounts
This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements. Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.
Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Regarding Item #3, I was not able to find the pdf attachment? Am I not seeing it? Thank you!

Thank for you help with this submission.

Janet Stone

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Reviewer

Created By:

Maria Mahmood on 05/16/2013 10:21 AM

Last Edited By:

Maria Mahmood

Submitted On:

05/16/2013 10:21 AM

Subject:

Thanks for the reply

Comments:

Hi Brian,
Thanks for providing a copy of the letter.
Maria Mahmood
860-226-5080

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Filer

Created By:

Brian Hoffmeister on 05/16/2013 09:51 AM

Last Edited By:

Brian Hoffmeister

Submitted On:

05/16/2013 09:51 AM

Subject:

Copy of Letter

Comments:

Please see the link below for a copy of the letter.

http://www.state.tn.us/insurance/documents/Comm_ltr_hhs020713.pdf

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Reviewer

Created By:

Maria Mahmood on 05/16/2013 08:03 AM

Last Edited By:

Maria Mahmood

Submitted On:

05/16/2013 08:04 AM

Subject:

Copy of Letter Request

Comments:

Hi Vicki,

Can we request a copy of that letter?

".... This was the assumption when her letter designated the service areas align with the geographic rating area and was clarified in yesterdays industry meeting."

State:	*Tennessee*	**Filing Company:**	*Cigna Health and Life Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*Medical Individual*		
Project Name/Number:	*Form and Rate Filing 1/1/2014/*		

Note To Filer

Created By:

Vicky Stotzer on 05/15/2013 10:23 AM

Last Edited By:

Vicky Stotzer

Submitted On:

05/15/2013 10:23 AM

Subject:

Service Area

Comments:

The Commissioner is requiring that the entire service area be covered in the individual and small group markets. The Chattanooga area only has two counties listed. Please revise or withdraw those plans. This was the assumption when her letter designated the service areas align with the geographic rating area and was clarified in yesterdays industry meeting.

Vicky

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Post Submission Update Request Processed On 06/21/2013

Status:	Allowed
Created By:	Maria Mahmood
Processed By:	Vicky Stotzer
Comments:	

Company Rate Information:

Company Name:Cigna Health and Life Insurance Company

Field Name	Requested Change	Prior Value
REQUESTED RATE:		
Projected Earned Premium:	9,056,732.000	9,054,511.000
Projected Incurred Claims:	7,245,385.000	7,243,609.000
Max:	1,027.290	1,046.700

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Form Schedule

Lead Form Number: INDTNCH042013

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 07/29/2013	INDTNCH042013	INDTNCH042013	POL	Initial		45.000	IND_TN_CH_Policy_072313_Clean.pdf
2	Approved 07/29/2013	INDTNCHSPEC042013	INDTNCHSPEC042013	POL	Initial		45.000	IND_TN_CH_Spec_062013_Clean.pdf
3	Approved 07/29/2013	INDAPPTN0413	INDAPPTN0413	AEF	Initial		45.000	865547X TN Off Exchange Indiv Application v02 brackets.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

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

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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.

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $[0-6,100] $[0-12,200]	**Out-of-Network Deductible** $[0-12,500] $[0-25,000]
Coinsurance	You and Your Family Members pay [0-40]% of Charges after the Policy Deductible.	You and Your Family Members pay [0-50]% after the Policy Deductible.
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** $[0-6,350] $[0-12,700] The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.	**Out-of-Network Out-of-Pocket Maximum** $[0-25,000] $[0-50,000] The following do not accumulate to the Out-of-Network Out of Pocket Maximum: Penalties and Policy Maximums.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prior Authorization Program		
Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed a] $500 penalty** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed a $60 penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]%
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% Deductible waived	You pay all but $30 per exam
Eyeglasses and Lenses for Children	0% Deductible waived	
Frames		You pay all but $30 per frame
Single Vision		You pay all but $25 per pair
Lined Bifocal		You pay all but $35 per pair
Lined Trifocal or Lenticular		You pay all but $45 per pair
Limited to one pair per year		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Contact Lenses for Children Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% Deductible waived	 You pay all but $75 per pair You pay all but $225 per pair
Physician Services		
Office Visit		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist, (including consultant, referral and second opinion services)	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Physician Services, continued		
Surgery in Physician's office	[0-40]%	[0-50]%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy	[0-40]%	[0-50]%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	[0-40]%	[0-50]%
In-hospital visits	[0-40]%	[0-50]%
Allergy testing and treatment/injections	[0-40]%	[0-50]%
Hearing Aids for children **Maximum one hearing aid per ear every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	[0-40]%	[0-50]%
Hospital Services		
Inpatient Hospital Services		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Emergency Admissions		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	[0-40]%	[0-50]%
Emergency Services		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Emergency Room	[0-40]%	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	[0-40]% for Ground or Air transport.	In-network benefit level for an emergency medical condition, otherwise [0-50]% for Ground or Air transport.
Urgent Care	[$75 Copayment per visit; Deductible waived] [0%]	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[0-40]%	[0-50]%
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	[0-40]%	[0-50]%
Free-standing/Independent lab or x-ray facility	[0-40]%	[0-50]%
Outpatient hospital lab or x-ray	[0-40]%	[0-50]%
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-40]%	[0-50]%
Habilitative Services Including Physical, Occupational, and Speech Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Womens' Contraceptive Services, Family Planning and Sterilization	No charge, no Deductible	[0-50]%
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[0-50]%
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-40]%	[0-50]%
Hospital Delivery charges	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prenatal testing or treatment and postnatal visit or treatment billed separately from "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child.	[0-40]%	[0-50]%
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-40]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-40]%	[0-50]%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year, combined In- and Out-of-Network, for all facilities listed	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	[0-40]%	[0-50]%
Durable Medical Equipment	[0-40]%	Not Covered
Prosthetics	[0-40]%	[0-50]%
Hospice Inpatient Outpatient	 [0-40]% [0-40]%	 [0-50]% [0-50]%
Dialysis Inpatient Outpatient	 Inpatient Hospital Services benefit applies [0-40]%	 Not Covered Not Covered
Autism Spectrum Disorders (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	[0-40]%	[0-50]%
Mental, Emotional or Functional Nervous Disorders Inpatient Outpatient	 [0-40]% [0-50]%	 [0-50]% [0-50]%
Substance Abuse Inpatient Rehabilitation Outpatient	 [0-40]% [0-40]%	 [0-50]% [0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility]**	0%	NOT APPLICABLE
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		
Other Cigna Network Facility	[0-40%]	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-40]%	[0-50]%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. **In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule.** **Covered in-network only**		
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum 30-day supply)**	
Tier 1: Retail Preferred Generic	[$4 Copayment, Deductible waived] [0%] per Prescription or refill	Not Covered
Tier 2: Retail Non-Preferred Generic	[$[10-20] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not Covered
Tier 3: Retail Preferred Brand	[$[20-60] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 4: Retail Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 5: Specialty generic and brand name medications		Not Covered

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
that meet criteria of specialty drugs	[0-30]% per Prescription or refill	
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not Covered
Cigna Tel-Drug Mail Order Pharmacy Drug Program	**(Maximum 90-day supply)** **(Maximum 30-day supply for Specialty Medications)**	
Tier 1: Mail Order Preferred Generic	[$10 Copayment, Deductible waived] [0%] per Prescription or refill	Not available
Tier 2: Mail Order Non-Preferred Generic	[$[25-50] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not available
Tier 3: Mail Order Preferred Brand	[$[50-150] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available
Tier 4: Mail Order Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	[0-30]% per Prescription or refill	Not available
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not available

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.

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

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

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.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Copayment/Copay is 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 and Reconstructive 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. 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”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of deductibles may apply to this Policy and all are defined in this section. See the definitions for Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

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

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational 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 its is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- it is the subject of an on-going clinical trial, except as provided in the “Clinical Trials” section of this plan.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Out-of-Pocket Maximum: Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Free-Standing Outpatient Surgical Facility
The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Out-of-Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification.

Injury means an accidental bodily injury.

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

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons;or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins on January 1st of each year. Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Service Area is any place that is within the counties and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, Lifetime, per visit, per day, or per event maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled “How The Policy Works”.

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached 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 or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna in writing within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month in the Year following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on the Federally Facilitated Marketplace ("on marketplace" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- 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.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on the Federally Facilitated Marketplace ("off-marketplace plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or

- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- When the Insured no longer lives in the Service Area.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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.

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

- If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.

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 Maximums;
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.

- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

In addition, the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;

- Not for exercise; and
- And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic, and Speech Therapy)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:
Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

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

Benefits for 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 are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional or Functional Nervous Disorders and Substance Abuse

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, ,or substance abuse must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, ,or substance abuse and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram.
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.

- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

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

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 if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Hearing Aids

Hearing aids for children are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses 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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

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

3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

a) self care and feeding,

b) pragmatic, receptive, and expressive language,

c) cognitive functioning,

d) applied behavior analysis, intervention, and modification,

e) motor planning, and

f) sensory processing.

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are not covered.
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.

- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV), for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

- Services typically provided absent a clinical trial.
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service.

- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service.
- Services required for reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs do not include—

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

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

Treatment of Diabetes

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

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

Home Health Care

To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

- 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.
- 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.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids**, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems, except as specifically stated in this policy.
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- 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.
- Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.

- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Plan Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment or Coinsurance will apply to each Prescription Drug.

In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copayment or Coinsurance shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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;
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Drugs that are not on the Prescription Drug List;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for Specialty Medications and Self-Administered Injectable Drugs, at a home delivery Pharmacy unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.

Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.

Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that You or Your Physician requests a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copayment or Coinsurance shown in the Schedule.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior

Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses per year, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

Coordination Of Benefits

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.
- If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and

- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: 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 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 intentional, 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one

full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
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, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

Any cancellation shall be without prejudice for any claim for Covered Expense 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 this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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.

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

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

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

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

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

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating

Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of

why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 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.

Cigna Health and Life Insurance Company
PO Box 30365
Tampa FL 33630-3365

Policy Specification Page

[Policy Name]
Benefit Option Code: [XXXX]

Insured:	[First, Last]		
Identification Number:	[XXXXXXXXX]	Policy Effective Date:	[mm/dd/yyyy]
Form Number:	**INDTNCH042013**	Plan Number	[XXXXXX]
Benefit Option Code:	[XXXX]	Annual Deductible	[$XXX]

This Policy Specification Page is part of and incorporated into the Policy identified by the Identification Number and Form Number shown above.

INSURED PERSON(S) UNDER THIS PLAN

Name	Original Effective Date	Monthly Premium
[xxxxxxxxxxxxxxxx]	[xxxxxxxxxxxxxxxxx]	[xxxxxxxxxxx]

Signed for CIGNA by:

Shermona Mapp, Corporate Secretary

[SUBSCRIBER NAME]
[ADDRESS]
[CITY STATE ZIPCODE] [BENEFIT OPTION CODE]

Primary Applicant Name_____
[Enrollment Form ID_____]

Cigna Health and Life Insurance Company (Cigna)
[Tennessee Individual and Family Plan Enrollment Application / Change Form]

[Our medical plans are only available in the following services areas/counties:]
[Chattanooga: Hamilton and Marion County
Memphis: Fayette, Haywood, Lauderdale, Shelby, Tipton
Nashville: Cheatham, Davidson, Montgomery, Robertson, Rutherford, Sumner, Trousdale, Williamson, Wilson]

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s)

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date:*
☐ 1st of the Month of_____
[☐ 15th of the Month of _____]

[Effective dates are assigned to the 1st or 15th of the month.] Cigna will assign the next available effective date if not selected by the applicant.

** Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or within 60 calendar days of a qualifying event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below)*
- ☐ An individual and any dependents lost minimum essential health coverage
- ☐ An individual gained or became a dependent through marriage, birth, adoption, or placement for adoption
- ☐ An individual experienced an error in enrollment
- ☐ An individual adequately demonstrated that the plan or issuer substantially violated a material provision of the contract in which s/he is enrolled
- ☐ An individual became newly eligible or ineligible for advance payments of the premium tax credit or is experiencing a change in eligibility for cost-sharing reductions
- ☐ An individual or enrollee made a permanent move and new coverage is available

For any Special Enrollment Period reason, provide:

Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Benefit Plan:

☐ [Plan Names]

☐ [Dental]

[I hereby represent and provide assurance to Cigna Health and Life Insurance Company that I ☐ **have** / ☐ **have not** obtained stand-alone pediatric dental insurance coverage offered by an Exchange-certified stand-alone dental plan. *(Check whichever is applicable).*]

Section D. Applicant, Spouse and Dependent Information

Applicant's Last Name:		First Name:		M.I.	Social Security Number:
Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number [Optional] _____ Current Patient: ☐ Yes ☐ No
Mailing Address – Home Address Required Street City State ZIP Code (Please provide 9-digit ZIP Code)		Billing Address – If different than mailing address P.O. Box / Street City State ZIP Code		County Email Address:	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____

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Spouse's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		[Open Access Plan Primary Care Physician ID Number [Optional] _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Dependent's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number [Optional] _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number [Optional] _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

D1. Are all enrollees residents of the United States? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

D2. Do all enrollees reside within Tennessee and within the service area of the selected benefit plan? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Coverage Information

E1. Does any applicant(s) have current health care coverage? ☐ Yes ☐ No

E2. Was any applicant(s) insured within the last **62** days? ☐ Yes ☐ No

E3. If any applicant answered "Yes" to any of the above, please provide the following information:
Name of prior or current Health plan carrier: _____ Type of Policy: _____
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination date: _____ Date Policy Paid Through: _____

E4. Each applicant must agree to cancel all other health policies or plans, including HMO or PPO coverage, providing benefits for health services similar to this plan.

Section F. Health Related Questions

F1. Has any applicant smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? ☐ Yes ☐ No
If yes, list applicant name(s) and the last time they smoked or used tobacco products:
Name(s): _____

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Section G. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section H. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) [and Credit Card] are the only initial payment methods allowed for online or faxed applications. [The accounts will be charged only upon approval of your Application.]

[Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments [(no paper or electronic monthly billing statement will be issued).]

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name of Bank:_____ Name(s) on Account:_____]

I authorize the Company (Cigna and Connecticut General Life Insurance Company) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.]

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

[Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:
☐ ☐ ☐ ☐ - ☐ ☐ ☐ ☐ - ☐ ☐ ☐ ☐ - ☐ ☐ ☐ ☐

Account Holder's ZIP Code: ___ ___ ___ ___ ___ – ___ ___ ___ ___

Card Expiration Date:]

Any premium adjustment will automatically be charged to your account.
Please be advised that the premium adjustment may reflect an increase.

For Paper Application: ***Please check here:*** ☐ Paper check is attached [or ☐ Credit card information provided.]

Ongoing Payment Options if paying by paper check [or credit card] for initial payment (please select one option only)

[☐ **Monthly Paper Bill:** Yes, I am submitting a paper check [(or have selected the credit card option)] for my initial payment. I will submit a check for my ongoing monthly payments.]

[☐ **Quarterly Paper Bill:** Yes, I am submitting a paper check [(or have selected the credit card option)] for my initial payment. I will submit a check for my ongoing [quarterly] payments. [(monthly billing option is not available for this ongoing payment method).]]

[☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment [(or have selected the credit card option)] and I am requesting recurring automatic EFT drafts for ongoing monthly payments. [(No paper or electronic monthly or quarterly billing statements will be issued.)] *Please complete the EFT section above.]*

[☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.]

[For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.]

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Section I. Statement of Accountability – *To be completed when applicant cannot complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the [Conditions and Agreement Section]:

_____ _____

Signature of Translator *required* — Today's Date *required*

(Excludes Parent Signature if Child Only Application)

Section J. Producer Section

Writing Producer Name:		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Are you aware of any information about your client not disclosed on this application?		☐ Yes ☐ No
Did you see the proposed applicant at the time this application was completed? If "No", please explain:_____		☐ Yes ☐ No
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.		
Signature of Writing Producer:		Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Cigna Sales Representative Last Name:		First Name:

Section K. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna.
- Effective dates are generally assigned to the [1st or 15th] of the month. The next available effective date will be assigned, if not selected by the applicant.

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Section L. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to defraud any insurance company or other person files application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits fraudulent insurance act and may be subject to civil and criminal penalties.
2. I authorize that payment be made under Part B of Medicare to Cigna for medical and other services furnished by Cigna for which it pays or has paid, if applicable.
3. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source Cigna may be authorized by applicable law to pursue, to fully inform Cigna and execute such documents and provide such assistance as may be necessary to enable Cigna to recover the value of services provided, arranged or covered.
4. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
5. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted, and (b) a contract has been issued by Cigna.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM.

All applicants 18 years and older must sign and date application, acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna benefit plan. I acknowledge and agree that any fraudulent misrepresentation of any applicant will render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna will refund all amounts paid by me except amounts owed to Cigna.

Applicant Signature:	Today's Date: (MM/DD/YYYY)	Applicant Spouse's Signature:	Today's Date: (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)

Section M. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Individual and Family Plans
[P.O. Box 30362
Tampa, FL 33630-3362]
[FAX # 877.484.5927]
[www.Cigna.com]

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State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Cigna Health and Life Insurance Company	New Product	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

Rate Review Detail

COMPANY:

Company Name:	Cigna Health and Life Insurance Company
HHS Issuer Id:	99248
Product Names:	LocalPlus
Trend Factors:	n/a

FORMS:

New Policy Forms:	INDTNCH042013
Affected Forms:	
Other Affected Forms:	

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Annual
Member Months:	0
Benefit Change:	None
Percent Change Requested:	Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium:	0.00
Total Incurred Claims:	0.00
Annual $:	Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium:	9,056,732.00
Projected Incurred Claims:	7,245,385.00
Annual $:	Min: 113.26 Max: 1,027.29 Avg: 293.00

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate pages	INDTNCH042013	New		TN.RateTables.v2.2.pdf,

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	121.07	151.34
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	21	190.66	238.33
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	22	190.66	238.33
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	23	190.66	238.33
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	24	190.66	238.33
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	25	191.42	239.28
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	26	195.24	244.05
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	27	199.81	249.77
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	28	207.25	259.06
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	29	213.35	266.69
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	30	216.40	270.50
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	31	220.97	276.22
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	32	225.55	281.94
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	33	228.41	285.52
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	34	231.46	289.33
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	35	232.99	291.24
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	36	234.51	293.15
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	37	236.04	295.05
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	38	237.56	296.96
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	39	240.61	300.77
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	40	243.66	304.59
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	41	248.24	310.31
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	42	252.62	315.79
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	43	258.73	323.41
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	44	266.35	332.95
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	45	275.31	344.15
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	46	285.99	357.50
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	47	298.00	372.51
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	48	311.73	389.67
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	49	325.27	406.59

99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	50	340.52	425.66
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	51	355.58	444.49
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	52	372.17	465.22
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	53	388.95	486.19
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	54	407.06	508.83
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	55	425.17	531.48
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	56	444.81	556.02
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	57	464.64	580.81
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	58	485.80	607.26
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	59	496.29	620.37
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	60	517.45	646.83
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	61	535.75	669.71
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	62	547.77	684.72
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	63	562.83	703.55
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	64	571.98	714.99
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	571.98	714.99
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	124.90	156.12
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	21	196.69	245.86
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	22	196.69	245.86
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	23	196.69	245.86
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	24	196.69	245.86
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	25	197.48	246.84
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	26	201.41	251.76
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	27	206.13	257.66
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	28	213.80	267.25
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	29	220.10	275.12
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	30	223.24	279.05
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	31	227.96	284.95
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	32	232.68	290.85
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	33	235.63	294.54
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	34	238.78	298.47
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	35	240.36	300.44
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	36	241.93	302.41
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	37	243.50	304.37
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	38	245.08	306.34
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	39	248.22	310.28
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	40	251.37	314.21
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	41	256.09	320.11
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	42	260.61	325.76
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	43	266.91	333.63
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	44	274.78	343.47
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	45	284.02	355.02
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	46	295.04	368.79
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	47	307.43	384.28
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	48	321.59	401.98
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	49	335.55	419.44
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	50	351.29	439.11
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	51	366.83	458.53
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	52	383.94	479.92

99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	53	401.25	501.55
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	54	419.93	524.91
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	55	438.62	548.27
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	56	458.88	573.59
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	57	479.33	599.16
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	58	501.17	626.45
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	59	511.98	639.97
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	60	533.82	667.26
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	61	552.70	690.87
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	62	565.09	706.36
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	63	580.63	725.78
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	64	590.07	737.58
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	590.07	737.58
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	143.34	179.17
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	21	225.73	282.16
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	22	225.73	282.16
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	23	225.73	282.16
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	24	225.73	282.16
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	25	226.63	283.29
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	26	231.15	288.93
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	27	236.57	295.70
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	28	245.37	306.71
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	29	252.59	315.74
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	30	256.20	320.25
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	31	261.62	327.02
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	32	267.04	333.80
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	33	270.42	338.03
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	34	274.04	342.54
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	35	275.84	344.80
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	36	277.65	347.06
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	37	279.45	349.31
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	38	281.26	351.57
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	39	284.87	356.09
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	40	288.48	360.60
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	41	293.90	367.37
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	42	299.09	373.86
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	43	306.32	382.89
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	44	315.34	394.18
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	45	325.95	407.44
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	46	338.60	423.24
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	47	352.82	441.02
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	48	369.07	461.33
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	49	385.10	481.36
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	50	403.15	503.94
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	51	420.99	526.23
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	52	440.62	550.78
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	53	460.49	575.61
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	54	481.93	602.41
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	55	503.38	629.22

99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	56	526.63	658.28
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	57	550.10	687.62
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	58	575.16	718.94
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	59	587.58	734.46
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	60	612.63	765.78
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	61	634.30	792.87
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	62	648.52	810.65
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	63	666.35	832.94
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	64	677.19	846.48
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	677.19	846.48
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	141.95	177.43
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	21	223.54	279.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	22	223.54	279.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	23	223.54	279.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	24	223.54	279.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	25	224.43	280.54
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	26	228.90	286.13
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	27	234.27	292.83
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	28	242.99	303.73
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	29	250.14	312.67
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	30	253.72	317.14
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	31	259.08	323.85
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	32	264.45	330.55
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	33	267.80	334.75
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	34	271.38	339.22
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	35	273.17	341.45
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	36	274.95	343.69
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	37	276.74	345.92
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	38	278.53	348.16
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	39	282.11	352.63
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	40	285.68	357.10
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	41	291.05	363.80
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	42	296.19	370.23
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	43	303.34	379.17
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	44	312.29	390.35
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	45	322.79	403.48
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	46	335.31	419.13
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	47	349.39	436.73
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	48	365.49	456.85
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	49	381.36	476.69
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	50	399.24	499.04
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	51	416.90	521.12
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	52	436.35	545.43
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	53	456.02	570.02
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	54	477.26	596.56
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	55	498.49	623.11
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	56	521.52	651.89
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	57	544.77	680.95
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	58	569.58	711.96

99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	59	581.87	727.33
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	60	606.69	758.35
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	61	628.15	785.17
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	62	642.23	802.77
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	63	659.89	824.85
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	64	670.62	838.26
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	670.62	838.26
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	146.82	183.52
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	21	231.21	289.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	22	231.21	289.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	23	231.21	289.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	24	231.21	289.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	25	232.13	290.17
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	26	236.76	295.95
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	27	242.31	302.88
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	28	251.33	314.15
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	29	258.72	323.40
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	30	262.42	328.03
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	31	267.97	334.96
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	32	273.52	341.90
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	33	276.99	346.23
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	34	280.69	350.86
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	35	282.54	353.17
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	36	284.39	355.48
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	37	286.24	357.79
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	38	288.09	360.11
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	39	291.79	364.73
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	40	295.49	369.35
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	41	301.04	376.29
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	42	306.35	382.94
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	43	313.75	392.19
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	44	323.00	403.75
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	45	333.87	417.33
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	46	346.82	433.52
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	47	361.38	451.72
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	48	378.03	472.53
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	49	394.44	493.05
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	50	412.94	516.17
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	51	431.21	539.00
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	52	451.32	564.15
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	53	471.67	589.58
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	54	493.63	617.04
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	55	515.60	644.49
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	56	539.41	674.26
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	57	563.46	704.32
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	58	589.12	736.40
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	59	601.84	752.29
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	60	627.50	784.37
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	61	649.70	812.12

99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	62	664.27	830.33
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	63	682.53	853.16
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	64	693.63	867.03
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	693.63	867.03
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	164.21	205.26
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	21	258.60	323.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	22	258.60	323.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	23	258.60	323.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	24	258.60	323.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	25	259.63	324.54
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	26	264.81	331.01
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	27	271.01	338.77
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	28	281.10	351.37
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	29	289.37	361.72
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	30	293.51	366.89
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	31	299.72	374.65
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	32	305.92	382.40
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	33	309.80	387.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	34	313.94	392.43
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	35	316.01	395.01
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	36	318.08	397.60
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	37	320.15	400.18
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	38	322.22	402.77
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	39	326.35	407.94
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	40	330.49	413.11
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	41	336.70	420.87
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	42	342.65	428.31
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	43	350.92	438.65
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	44	361.26	451.58
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	45	373.42	466.77
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	46	387.90	484.88
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	47	404.19	505.24
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	48	422.81	528.51
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	49	441.17	551.46
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	50	461.86	577.32
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	51	482.29	602.86
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	52	504.79	630.98
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	53	527.54	659.43
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	54	552.11	690.14
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	55	576.68	720.85
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	56	603.31	754.14
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	57	630.21	787.76
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	58	658.91	823.64
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	59	673.14	841.42
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	60	701.84	877.30
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	61	726.67	908.33
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	62	742.96	928.70
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	63	763.39	954.23
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	64	775.80	969.75

99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	775.80	969.75
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	173.95	217.44
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	21	273.94	342.43
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	22	273.94	342.43
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	23	273.94	342.43
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	24	273.94	342.43
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	25	275.04	343.80
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	26	280.51	350.65
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	27	287.09	358.87
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	28	297.77	372.22
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	29	306.54	383.18
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	30	310.92	388.66
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	31	317.50	396.88
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	32	324.07	405.09
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	33	328.18	410.23
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	34	332.56	415.71
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	35	334.75	418.45
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	36	336.95	421.19
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	37	339.14	423.93
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	38	341.33	426.67
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	39	345.71	432.15
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	40	350.10	437.63
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	41	356.67	445.84
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	42	362.97	453.72
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	43	371.74	464.68
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	44	382.69	478.37
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	45	395.57	494.47
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	46	410.91	513.65
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	47	428.17	535.22
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	48	447.89	559.87
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	49	467.34	584.19
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	50	489.26	611.58
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	51	510.90	638.63
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	52	534.73	668.42
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	53	558.84	698.56
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	54	584.86	731.09
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	55	610.89	763.62
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	56	639.10	798.89
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	57	667.59	834.50
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	58	698.00	872.51
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	59	713.07	891.35
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	60	743.47	929.36
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	61	769.77	962.23
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	62	787.03	983.80
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	63	808.67	1010.85
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	64	821.82	1027.29
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	821.82	1027.29
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	119.82	149.78
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	21	188.70	235.88

99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	22	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	23	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	24	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	25	189.45	236.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	26	193.23	241.54
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	27	197.76	247.20
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	28	205.12	256.40
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	29	211.16	263.95
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	30	214.17	267.72
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	31	218.70	273.38
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	32	223.23	279.05
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	33	226.06	282.58
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	34	229.08	286.36
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	35	230.59	288.25
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	36	232.10	290.13
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	37	233.61	292.02
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	38	235.12	293.91
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	39	238.14	297.68
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	40	241.16	301.45
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	41	245.69	307.12
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	42	250.03	312.54
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	43	256.07	320.09
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	44	263.61	329.52
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	45	272.48	340.61
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	46	283.05	353.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	47	294.94	368.68
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	48	308.52	385.66
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	49	321.92	402.41
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	50	337.02	421.28
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	51	351.93	439.92
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	52	368.34	460.44
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	53	384.95	481.20
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	54	402.87	503.60
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	55	420.80	526.01
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	56	440.24	550.31
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	57	459.86	574.84
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	58	480.81	601.02
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	59	491.19	614.00
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	60	512.13	640.18
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	61	530.25	662.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	62	542.14	677.68
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	63	557.04	696.32
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	64	566.10	707.64
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	566.10	707.64
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	123.62	154.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	21	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	22	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	23	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	24	194.67	243.33

99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	25	195.45	244.30
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	26	199.34	249.17
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	27	204.01	255.01
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	28	211.61	264.50
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	29	217.84	272.29
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	30	220.95	276.18
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	31	225.62	282.02
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	32	230.29	287.86
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	33	233.21	291.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	34	236.33	295.40
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	35	237.89	297.35
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	36	239.44	299.30
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	37	241.00	301.24
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	38	242.56	303.19
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	39	245.67	307.08
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	40	248.79	310.98
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	41	253.46	316.82
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	42	257.94	322.41
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	43	264.17	330.20
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	44	271.95	339.93
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	45	281.10	351.37
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	46	292.01	365.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	47	304.27	380.32
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	48	318.29	397.84
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	49	332.11	415.12
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	50	347.68	434.59
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	51	363.06	453.81
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	52	380.00	474.98
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	53	397.13	496.39
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	54	415.62	519.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	55	434.11	542.63
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	56	454.17	567.69
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	57	474.41	593.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	58	496.02	620.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	59	506.73	633.39
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	60	528.33	660.40
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	61	547.02	683.76
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	62	559.29	699.09
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	63	574.67	718.31
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	64	584.01	729.99
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	584.01	729.99
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	141.87	177.33
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	21	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	22	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	23	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	24	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	25	224.30	280.38
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	26	228.77	285.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	27	234.13	292.66

99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	28	242.85	303.56
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	29	250.00	312.49
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	30	253.57	316.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	31	258.93	323.66
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	32	264.29	330.36
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	33	267.65	334.55
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	34	271.22	339.02
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	35	273.01	341.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	36	274.79	343.49
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	37	276.58	345.72
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	38	278.37	347.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	39	281.94	352.43
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	40	285.52	356.89
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	41	290.88	363.60
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	42	296.02	370.02
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	43	303.17	378.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	44	312.10	390.13
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	45	322.60	403.25
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	46	335.12	418.89
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	47	349.19	436.48
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	48	365.28	456.59
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	49	381.14	476.42
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	50	399.01	498.76
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	51	416.66	520.82
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	52	436.10	545.12
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	53	455.76	569.69
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	54	476.98	596.22
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	55	498.20	622.75
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	56	521.22	651.51
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	57	544.45	680.56
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	58	569.25	711.55
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	59	581.54	726.91
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	60	606.33	757.91
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	61	627.78	784.72
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	62	641.86	802.31
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	63	659.51	824.38
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	64	670.23	837.78
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	670.23	837.78
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	140.49	175.61
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	21	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	22	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	23	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	24	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	25	222.12	277.66
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	26	226.55	283.19
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	27	231.86	289.82
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	28	240.49	300.61
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	29	247.57	309.46
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	30	251.11	313.88

99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	31	256.42	320.52
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	32	261.73	327.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	33	265.05	331.31
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	34	268.59	335.73
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	35	270.36	337.94
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	36	272.13	340.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	37	273.90	342.37
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	38	275.67	344.58
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	39	279.20	349.01
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	40	282.74	353.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	41	288.05	360.07
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	42	293.14	366.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	43	300.22	375.28
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	44	309.07	386.34
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	45	319.47	399.34
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	46	331.86	414.83
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	47	345.80	432.25
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	48	361.73	452.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	49	377.44	471.79
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	50	395.13	493.92
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	51	412.61	515.77
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	52	431.86	539.83
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	53	451.33	564.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	54	472.35	590.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	55	493.37	616.71
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	56	516.15	645.19
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	57	539.16	673.95
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	58	563.72	704.65
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	59	575.89	719.86
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	60	600.45	750.56
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	61	621.68	777.11
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	62	635.62	794.53
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	63	653.10	816.38
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	64	663.72	829.65
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	663.72	829.65
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	145.31	181.63
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	21	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	22	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	23	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	24	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	25	229.75	287.17
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	26	234.32	292.89
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	27	239.81	299.76
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	28	248.74	310.91
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	29	256.06	320.07
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	30	259.72	324.64
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	31	265.21	331.51
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	32	270.71	338.37
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	33	274.14	342.66

99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	34	277.80	347.24
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	35	279.63	349.53
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	36	281.46	351.82
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	37	283.29	354.11
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	38	285.12	356.39
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	39	288.78	360.97
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	40	292.44	365.55
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	41	297.94	372.41
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	42	303.20	378.99
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	43	310.52	388.14
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	44	319.68	399.58
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	45	330.43	413.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	46	343.25	429.05
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	47	357.66	447.06
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	48	374.14	467.66
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	49	390.38	487.97
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	50	408.69	510.85
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	51	426.77	533.45
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	52	446.68	558.33
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	53	466.81	583.50
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	54	488.55	610.67
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	55	510.29	637.85
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	56	533.86	667.31
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	57	557.66	697.06
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	58	583.06	728.80
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	59	595.64	744.54
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	60	621.04	776.29
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	61	643.01	803.74
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	62	657.43	821.76
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	63	675.51	844.36
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	64	686.49	858.09
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	686.49	858.09
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	162.52	203.16
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	21	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	22	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	23	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	24	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	25	256.96	321.21
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	26	262.08	327.61
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	27	268.23	335.29
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	28	278.21	347.76
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	29	286.40	358.00
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	30	290.49	363.12
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	31	296.63	370.80
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	32	302.78	378.48
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	33	306.62	383.28
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	34	310.71	388.40
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	35	312.76	390.95
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	36	314.81	393.51

99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	37	316.85	396.07
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	38	318.90	398.63
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	39	323.00	403.75
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	40	327.09	408.87
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	41	333.23	416.55
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	42	339.12	423.91
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	43	347.31	434.15
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	44	357.55	446.94
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	45	369.58	461.98
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	46	383.91	479.90
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	47	400.03	500.05
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	48	418.46	523.09
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	49	436.63	545.80
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	50	457.11	571.39
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	51	477.33	596.67
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	52	499.59	624.50
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	53	522.12	652.66
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	54	546.43	683.05
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	55	570.75	713.44
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	56	597.11	746.40
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	57	623.73	779.67
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	58	652.14	815.18
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	59	666.21	832.78
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	60	694.62	868.29
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	61	719.19	899.00
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	62	735.32	919.16
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	63	755.53	944.43
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	64	767.82	959.79
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	767.82	959.79
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	172.16	215.20
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	21	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	22	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	23	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	24	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	25	272.20	340.26
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	26	277.63	347.03
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	27	284.13	355.17
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	28	294.71	368.38
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	29	303.38	379.23
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	30	307.72	384.65
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	31	314.23	392.79
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	32	320.73	400.92
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	33	324.80	406.00
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	34	329.14	411.42
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	35	331.31	414.14
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	36	333.48	416.85
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	37	335.65	419.56
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	38	337.82	422.27
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	39	342.15	427.69

99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	40	346.49	433.11
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	41	353.00	441.25
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	42	359.23	449.04
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	43	367.91	459.89
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	44	378.75	473.44
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	45	391.50	489.37
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	46	406.68	508.35
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	47	423.76	529.70
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	48	443.28	554.10
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	49	462.53	578.16
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	50	484.22	605.28
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	51	505.64	632.05
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	52	529.23	661.53
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	53	553.08	691.36
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	54	578.84	723.55
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	55	604.60	755.75
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	56	632.52	790.65
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	57	660.72	825.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	58	690.81	863.52
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	59	705.73	882.16
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	60	735.82	919.77
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	61	761.85	952.31
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	62	778.93	973.66
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	63	800.35	1000.43
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	64	813.36	1016.70
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	813.36	1016.70
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	113.26	141.57
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	21	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	22	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	23	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	24	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	25	179.07	223.84
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	26	182.64	228.30
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	27	186.92	233.65
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	28	193.88	242.35
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	29	199.58	249.48
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	30	202.44	253.05
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	31	206.72	258.40
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	32	211.00	263.75
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	33	213.68	267.09
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	34	216.53	270.66
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	35	217.96	272.44
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	36	219.38	274.23
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	37	220.81	276.01
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	38	222.24	277.80
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	39	225.09	281.36
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	40	227.94	284.93
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	41	232.22	290.28
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	42	236.33	295.41

99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	43	242.03	302.54
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	44	249.17	311.46
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	45	257.55	321.94
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	46	267.54	334.43
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	47	278.78	348.47
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	48	291.62	364.52
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	49	304.28	380.35
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	50	318.55	398.19
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	51	332.64	415.80
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	52	348.16	435.20
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	53	363.85	454.82
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	54	380.80	476.00
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	55	397.74	497.18
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	56	416.11	520.14
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	57	434.66	543.33
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	58	454.46	568.08
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	59	464.27	580.34
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	60	484.07	605.09
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	61	501.19	626.49
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	62	512.43	640.54
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	63	526.52	658.15
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	64	535.08	668.85
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	535.08	668.85
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	116.83	146.04
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	21	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	22	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	23	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	24	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	25	184.73	230.91
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	26	188.41	235.51
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	27	192.82	241.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	28	200.00	250.00
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	29	205.88	257.36
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	30	208.83	261.04
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	31	213.24	266.56
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	32	217.66	272.08
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	33	220.42	275.53
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	34	223.36	279.21
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	35	224.84	281.05
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	36	226.31	282.89
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	37	227.78	284.73
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	38	229.25	286.57
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	39	232.20	290.25
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	40	235.14	293.93
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	41	239.55	299.45
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	42	243.79	304.74
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	43	249.67	312.10
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	44	257.03	321.30
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	45	265.68	332.11

99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	46	275.99	344.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	47	287.58	359.47
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	48	300.82	376.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	49	313.89	392.36
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	50	328.61	410.76
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	51	343.14	428.93
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	52	359.15	448.94
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	53	375.34	469.18
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	54	392.82	491.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	55	410.30	512.88
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	56	429.25	536.57
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	57	448.38	560.49
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	58	468.81	586.01
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	59	478.93	598.66
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	60	499.35	624.19
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	61	517.01	646.27
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	62	528.60	660.76
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	63	543.14	678.93
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	64	551.97	689.97
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	551.97	689.97
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	134.09	167.61
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	21	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	22	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	23	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	24	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	25	212.00	265.01
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	26	216.23	270.28
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	27	221.30	276.62
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	28	229.53	286.91
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	29	236.29	295.36
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	30	239.67	299.58
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	31	244.73	305.92
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	32	249.80	312.25
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	33	252.97	316.21
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	34	256.35	320.44
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	35	258.04	322.55
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	36	259.73	324.66
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	37	261.42	326.77
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	38	263.11	328.88
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	39	266.48	333.10
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	40	269.86	337.33
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	41	274.93	343.66
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	42	279.79	349.73
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	43	286.54	358.18
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	44	294.99	368.74
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	45	304.92	381.14
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	46	316.74	395.93
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	47	330.04	412.55
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	48	345.25	431.56

99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	49	360.24	450.30
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	50	377.13	471.41
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	51	393.81	492.27
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	52	412.18	515.23
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	53	430.77	538.46
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	54	450.83	563.53
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	55	470.89	588.61
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	56	492.64	615.80
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	57	514.60	643.25
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	58	538.04	672.54
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	59	549.65	687.06
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	60	573.09	716.36
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	61	593.36	741.70
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	62	606.66	758.33
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	63	623.34	779.18
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	64	633.48	791.85
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	633.48	791.85
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	132.78	165.98
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	21	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	22	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	23	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	24	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	25	209.95	262.44
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	26	214.13	267.66
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	27	219.15	273.94
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	28	227.30	284.13
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	29	233.99	292.50
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	30	237.34	296.68
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	31	242.36	302.95
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	32	247.38	309.22
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	33	250.51	313.15
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	34	253.86	317.33
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	35	255.53	319.42
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	36	257.21	321.51
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	37	258.88	323.60
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	38	260.55	325.69
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	39	263.90	329.87
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	40	267.24	334.06
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	41	272.26	340.33
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	42	277.07	346.34
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	43	283.76	354.71
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	44	292.13	365.16
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	45	301.95	377.45
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	46	313.67	392.09
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	47	326.84	408.55
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	48	341.89	427.37
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	49	356.74	445.93
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	50	373.47	466.84
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	51	389.99	487.49

99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	52	408.18	510.23
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	53	426.58	533.24
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	54	446.45	558.07
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	55	466.32	582.90
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	56	487.85	609.82
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	57	509.60	637.01
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	58	532.81	666.02
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	59	544.31	680.40
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	60	567.52	709.41
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	61	587.60	734.51
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	62	600.77	750.97
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	63	617.29	771.62
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	64	627.33	784.17
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	627.33	784.17
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	137.34	171.67
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	21	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	22	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	23	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	24	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	25	217.15	271.43
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	26	221.47	276.84
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	27	226.66	283.33
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99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	29	242.02	302.52
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	30	245.48	306.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	31	250.67	313.34
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	32	255.86	319.82
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	33	259.10	323.88
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	34	262.56	328.20
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	35	264.29	330.37
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	36	266.02	332.53
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	37	267.75	334.69
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	38	269.48	336.86
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	39	272.95	341.18
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99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	41	281.60	352.00
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99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	43	293.49	366.86
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	44	302.14	377.68
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	45	312.31	390.39
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	46	324.42	405.53
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	47	338.05	422.56
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	48	353.62	442.02
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	49	368.97	461.22
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	50	386.28	482.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	51	403.36	504.20
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	52	422.18	527.72
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99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	54	461.76	577.20

99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	55	482.30	602.88
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	56	504.58	630.73
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	57	527.07	658.84
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	58	551.08	688.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	59	562.98	703.72
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	60	586.98	733.73
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	61	607.75	759.68
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	62	621.37	776.72
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	63	638.46	798.07
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	64	648.84	811.05
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	648.84	811.05
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	153.61	192.02
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	21	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	22	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	23	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	24	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	25	242.88	303.60
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	26	247.72	309.65
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	27	253.52	316.90
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	28	262.96	328.70
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	29	270.70	338.37
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	30	274.57	343.21
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	31	280.37	350.47
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	32	286.18	357.73
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	33	289.81	362.26
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	34	293.68	367.10
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	35	295.61	369.52
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	36	297.55	371.94
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	37	299.48	374.36
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	38	301.42	376.78
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	39	305.29	381.62
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	40	309.16	386.45
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	41	314.97	393.71
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	42	320.53	400.67
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	43	328.27	410.34
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	44	337.95	422.44
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	45	349.32	436.65
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	46	362.87	453.59
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	47	378.11	472.64
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	48	395.52	494.41
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	49	412.70	515.88
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	50	432.05	540.07
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	51	451.16	563.96
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	52	472.21	590.27
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	53	493.50	616.88
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	54	516.48	645.60
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	55	539.46	674.33
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	56	564.38	705.48
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	57	589.53	736.92

99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	58	616.39	770.49
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	59	629.69	787.12
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	60	656.54	820.69
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	61	679.77	849.72
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	62	695.01	868.77
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	63	714.12	892.66
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	64	725.73	907.17
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	725.73	907.17
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	162.73	203.41
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	21	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	22	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	23	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	24	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	25	257.29	321.61
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	26	262.41	328.02
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	27	268.56	335.71
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	28	278.55	348.20
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	29	286.75	358.45
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	30	290.86	363.57
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	31	297.01	371.26
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	32	303.16	378.95
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	33	307.00	383.76
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	34	311.10	388.88
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	35	313.15	391.44
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	36	315.20	394.01
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	37	317.25	396.57
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	38	319.30	399.13
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	39	323.40	404.26
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	40	327.50	409.38
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	41	333.65	417.07
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	42	339.54	424.44
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	43	347.74	434.69
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	44	358.00	447.50
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	45	370.04	462.56
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	46	384.39	480.50
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	47	400.53	500.68
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	48	418.99	523.74
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	49	437.18	546.48
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	50	457.68	572.11
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	51	477.92	597.42
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	52	500.22	625.28
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	53	522.77	653.47
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	54	547.12	683.90
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	55	571.46	714.34
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	56	597.85	747.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	57	624.51	780.64
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	58	652.95	816.20
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	59	667.04	833.82
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	60	695.49	869.38

99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	61	720.09	900.13
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	62	736.23	920.31
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	63	756.48	945.61
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	64	768.78	960.99
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	768.78	960.99

Supporting Document Schedules

Bypassed - Item:	Accident & Health - Individual New Rates
Bypass Reason:	See rate/rule schedule.
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	Actuarial Memorandum A & H Certification - Individual
Bypass Reason:	Included with memorandum
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Cover Letter Accident & Health
Comments:	
Attachment(s):	TN.CoverLetter.04.23.2013.pdf
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	Description of Variables
Bypass Reason:	All ranges contain each and every variable value. No values not shown will be used. Any text pieces bracketed will be included or excluded as shown within bracketing. No text pieces not shown will be used.
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	Filing Fees
Bypass Reason:	Connecticut does not charge a filing fee.

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	PPACA Uniform Compliance Summary
Bypass Reason:	This submission prompted no changes to the PPACA Uniform Compliance Summary.
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	Third Party Authorization
Bypass Reason:	This is not a third party filing
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	TNINDReadability.pdf
Item Status:	Approved
Status Date:	07/29/2013

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	n/a
Attachment(s):	
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	

Attachment(s):	TN.Part3ActuarialMemorandum.06.13.13.99248.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	TN.UnifiedRateReviewSubmission.v1.6.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Unique plan Design certification
Comments:	
Attachment(s):	UniquePlanDesign_99248TN0020001_thru_99248TN0020007.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	AVP inputs
Comments:	
Attachment(s):	TN.AVCInputs.05.15.2013.99248.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Rating Business Rules
Comments:	
Attachment(s):	TN.RatingBusinessRules.v1.5.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Redlined Documents

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Comments:	
Attachment(s):	IND_TN_CH_Spec_042013_Redline.pdf IND_TN_CH_Policy_042013_Redline.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Plan Benefits
Comments:	
Attachment(s):	TN.PlansBenefitsv1.31.04.24.2013.1.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Benefit Schedules
Comments:	
Attachment(s):	Benefit Schedules.xls
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Rate Response Letter
Comments:	
Attachment(s):	Rate objection CCGH-129001002 Response.pdf
Item Status:	Approved
Status Date:	07/29/2013

Satisfied - Item:	Redline Policy 7-12-13
Comments:	
Attachment(s):	IND_TN_CH_Policy_071113_Redline.pdf
Item Status:	Approved
Status Date:	07/29/2013

State: *Tennessee* **Filing Company:** *Cigna Health and Life Insurance Company*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*
Product Name: *Medical Individual*
Project Name/Number: *Form and Rate Filing 1/1/2014/*

Satisfied - Item:	Redline Policy 7-23-13
Comments:	
Attachment(s):	IND_TN_CH_Policy_072313_Redline.pdf
Item Status:	Approved
Status Date:	07/29/2013

State: Tennessee **Filing Company:** Cigna Health and Life Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: Medical Individual
Project Name/Number: Form and Rate Filing 1/1/2014/

Attachment Benefit Schedules.xls is not a PDF document and cannot be reproduced here.

Lauren Danziger, FSA, MAAA
Actuary
Cigna HealthCare Pricing

Routing C5PRC
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.6586
Lauren.Danziger@Cigna.com

April 23, 2013

Ms. Victoria L. Stotzer
Tennessee Department of Commerce and Insurance
Actuarial Section, 4th Floor
500 James Robertson Parkway
Nashville, Tennessee 37243-1130

RE: Cigna Health and Life Insurance Company
NAIC Company ID#: 67369
Rate Filing for Individual Health Plans
INDTNCH042013 – Effective 01/01/2014

Dear Ms. Stotzer,

This filing contains initial premium rates for Cigna Health and Life Insurance Company's (CHLIC) new ACA compliant Individual plans. The proposed rates are to be effective January 1, 2014. These plans replace CHLIC's previous non-ACA compliant plans, approved under SERFF tracking number CCGH-128754563.

Enclosed within this filing are the Unified Rate Review Submission, Part 3 Actuarial Memorandum, Rate Tables, Business Rules, Unique Plan Design Certification and AVC Inputs.

CHLIC requests confidential handling of this filing. We believe that this information is proprietary and critical to our business. The release of such information could be harmful if made public.

Please contact Mitchell Pawlowski at 860.226.4565 or at Mitchell.Pawlowski@Cigna.com with any questions or concerns.

Thank you for your attention.

Sincerely,

Lauren Danziger

Lauren Danziger, FSA, MAAA
Actuarial Manager

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Cigna HEALTH and LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with the readability laws in **Tennessee**.

A. Option Selected

Policy and related forms are scored collectively for the Flesch reading ease test. The collective score for the policy forms and each related form is indicated below:

Form and Form Numbers to Which Certification is Applicable:

Form	Form Number	Flesch Score
Individual Policy	INDTNCH042013 et al	45

B. Test Option Selected

Test was applied to individual policy insert pages(s) and individual certificate insert pages(s).

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score on the Flesch reading ease test in accordance with section A above.

2. It is printed in not less than ten-point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

3. The layout and spacing separate the paragraphs from each other and from the border of the paper.

4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.

5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.

6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.

7. A table of contents or an index of the principal sections is included in the policy.

8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.

Edmund J. Skowronek, Jr.

Edmund J. Skowronek, Jr. Director April 25, 2013
Date

1. GENERAL INFORMATION

Insurance Company Name	Cigna Health & Life Insurance Company
NAIC Company Code	67369
HIOS Issuer ID	99248
State	Tennessee
Market Type	Individual
Proposed Effective Date	01/01/2014
Primary Contact Person and Title	Lauren Danziger, FSA, MAAA, Actuarial Manager
Primary Contact Telephone Number	(860) 226-6586
Primary Contact Email	Lauren.Danziger@Cigna.com

Scope and Purpose of Filing: Cigna Health & Life Insurance Company (CHLIC) is filing rates for comprehensive major medical products for individuals & families to be effective January 1, 2014. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to a new product that has been submitted under policy form filing INDTNCH042013. This policy form is not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

CHLIC is the Cigna Company that is applying for certification as a Qualified Health Plan. Until recently, Cigna conducted its group and individual health insurance business through Connecticut General Life Insurance Company (CGLIC). Several years ago (pre-PPACA), Cigna made the business decision to cease writing insurance coverage through CGLIC and to migrate all existing and new business to CHLIC, which is a subsidiary of CGLIC. The timing of the migration of all health insurance business to CHLIC, by coincidence, results in CHLIC being used exclusively for new business in 2014. Accordingly, CHLIC is the Cigna Company that is applying for certification as a Qualified Health Plan.

2. PROPOSED RATE INCREASE

This will be the first year that individual health insurance coverage will be offered by CHLIC in this state. Since this is a filing for a new product, there is no rate increase associated with this filing. Consequently, the rates for the proposed plans in this filing should not be considered a rate increase or decrease because there is no current membership for CHLIC.

3. EXPERIENCE PERIOD PREMIUM & CLAIMS

As mentioned above, since this will be the first year that individual coverage will be offered by this company in this state, there is no experience to report in Section 1, Worksheet 1, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience, but they will show in the URR template and will cause cells V45 and V46 on Worksheet 1 and row 27 on Worksheet 2 of the template to indicate a rate increase over the experience period, but these values have only populated due to the minimal values referenced above. Similarly, Sections 2 and 3 of Worksheet 2 have been populated with minimal values and row 46 is reflecting an average 2014 rate instead of an average 'current' rate in order for the formulas to work properly in the template.

a. Paid Through Date: N/A
b. Premiums (Net of MLR): N/A
c. Allowed & Incurred Claims: N/A

4. BENEFIT CATEGORIES

To determine benefit categories, CHLIC uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Prescription Drug: Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

As mentioned earlier, since CHLIC currently does not have any business in the Individual Market in Tennessee, there is no experience data available for the company. Hence, no experience is shown for Worksheet 1, Section 2, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience.

5. PROJECTION FACTORS

Since CHLIC currently does not have any business in the Individual Market in Tennessee, there is no experience data or projection factors shown for the experience period in Worksheet 1, Section 2, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience data or projection factors.

6. CREDIBILITY MANUAL RATE DEVELOPMENT

a. Source & Appropriateness of Experience Data used in Developing the Manual Rate

The source data used to generate the Manual Rate is trended national group experience adjusted for state and market specific differences. The experience for the national group book of business is deemed appropriate to be used for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are more similar to the benefits required to be ACA compliant than any other experience available. We address the adjustments to the baseline data below.

b. Adjustments made to the Data

The following adjustments were made during development of the Manual Rate to account for differences between the source data and characteristics of the anticipated population in the Individual Market for the proposed period:

- Morbidity Load – A 5% load was added to the Manual Rate to account for the difference in morbidity risk of the population underlying the Manual Rate and the anticipated population of the Individual Market in 2014. The morbidity load is in consideration of the following components:
    - The influx of members from high-risk pools, HIPAA, and conversion policies into the Individual Market. These types of plans are already guarantee issue, but morbidity factors are currently permitted for these specific plans compared with the rest of the individual market. Since all plans will be based on a single risk pool in 2014, the overall index rate has been developed with the anticipation that current policyholders in the afore-mentioned pools, are expected to enter or remain in the individual market and enroll on the new ACA compliant plans.
    - The influx of new entrants who were previously uninsured. According to the SOA sponsored study "Cost of the Future Newly Insured under the ACA", individuals who are currently uninsured have different average morbidity risk than the current individual market. As these uninsured enter the individual market in 2014, morbidity risk is expected to change.
    - Plan selection – Since all individuals will be part of a single risk pool in 2014 with no medical underwriting, it is expected that individuals with higher morbidity will select plans that will best meet their needs (i.e. plans with lower member cost share). To account for the impact of this selection, the overall index rate has been adjusted to reflect the increased utilization that stems from the selection of plans with lower cost share for individuals with higher

morbidity risk. This adjustment is applied to the index rate only and no plan-specific adjustments are being made to account for anticipated differences in health status of enrollees across plans.

- Pent-up demand – newly insured individuals in 2014 are anticipated to have a higher consumption rate of services as they hold off on medical services prior to being insured. While this increase in utilization is anticipated to be minimal overall, it is still expected to increase the average utilization rate for the individual market in 2014.
- The underlying experience data is based on a population of both non-smokers and smokers, so the experience has been adjusted to be reflective of a non-smoking population. The index rate is appropriate for a non-tobacco user. Tobacco users will see a 25% load on top of the non-tobacco user rate.
- CSR plan induced utilization – individuals who qualify for CSR variations of silver plans may have different utilization patterns than individuals on standard silver plans because a higher consumption rate of services is anticipated when benefits have lower member cost-share. The impact of this occurrence, although minimal, has been included in the morbidity load and is expected to increase average utilization for the individual market in 2014.

- Demographic Adjustment – The experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, a minimal adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2014 individual market as opposed to the distribution by age reflected in the data underlying the Manual Rate.
- Impact of EHB – Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a 0.2% load.
- Network Savings – CHLIC's underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. The estimated savings of the new provider network vary by geographic region, but are incorporated into the Manual Rate based on assumed enrollment by region as an average 5.2% decrement.

c. Inclusion of Capitation Payments

There are no services provided under a capitation arrangement for plans included in this filing.

7. CREDIBILITY OF EXPERIENCE

Since there is no experience data in Worksheet 1 of the Part 1 URR Template, 100% credibility is assigned to the Manual Rate. We believe that the Manual Rate is appropriate for developing rates for the plans in this filing, as explained in sections 6(a) and 6(b).

8. PAID TO ALLOWED RATIO

The expected cost-sharing ratio for each benefit plan is calculated by using group experience over the experience period (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then utilized to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-share estimates. The expected distribution of business by benefit plan originates from CHLIC's internal estimates.

The paid-to-allowed ratio for each plan in this filing is consistent with the Actuarial Value of the plans. However, fluctuations do exist as a result of differences in the experience underlying CHLIC's manual rate and the experience underlying the continuance tables in the AV calculator. These dissimilarities result from the following differences:

- The CPD used to calculate member vs. insurer cost-share is different from the underlying claims distribution in the continuance tables of the AV Calculator. The continuance tables are based on the default standard population developed by HHS using 2010 claims and enrollment from a national commercial database. The CPD, on the other hand, is based on claims and enrollment data from Cigna's national group book of business. This experience based CPD has a larger volume of its distribution at the tail, which represents higher average costs.
- The underlying cost assumptions for copays in the AV Calculator are different than the cost assumptions determined by Cigna's experience. Since most of the proposed plans represented in this filing have copay based cost-sharing for Primary Care Physician and Specialist office visits, this causes a difference between the Paid-to-Allowed ratio and the Metal AV for most plans.

- The AV Tool only accounts for in-network benefits, whereas the paid-to-allowed ratio incorporates the impact of out-of-network benefits as well.
- Cost-sharing for certain benefits, such as separate copays for urgent care, is not captured in the AV Tool, whereas CHLIC takes these benefits into account when deriving the paid-to-allowed ratio.

9. RISK ADJUSTMENT & REINSURANCE

a. Projected Risk Adjustments (PMPM)

CHLIC is not expecting Risk Adjustment to have an impact on its index rate. While it is likely to see risk transfer payments across plans due to differences in enrolled distributions by metal level and age, CHLIC anticipates the net impact of these transfers to be negligible across the entire portfolio. The index rate has been developed to represent our expectation of the industry average medical costs as well as distribution of enrollment by age & metal tier for the Individual Market for 2014. Since we expect that CHLIC will get the same proportion by age and plan of the market as all other companies and we have factored this into the development of the index rate, there is no expected transfer payment.

b. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

To estimate reinsurance contributions, an annual contribution of $63 per covered life is assumed. Reinsurance payments have been estimated using a representative sample of nationwide group claims data. This data consisted of member-level claims data from October 2011 through November 2012 trended to a 2014 basis. In our analysis, it is not anticipated that the increased morbidity risk will cause a higher distribution of claims to fall within or outside the parameters set for the reinsurance program. We believe that this claims data is representative of the annual distribution of claims per member we expect in 2014. Based on our claims data and the federal reinsurance parameters, we estimate that reinsurance will cover 12.5% of paid claims. This 12.5% decrement to medical costs is applied evenly across all plans as a constant multiplicative factor.

The net effect on plan costs (contributions minus payments) is expected to be $28.82 PMPM. Since reinsurance payments are calculated as a percentage of medical costs, but the contribution is a fixed PMPY, the expected impact PMPM is based on CHLIC's assumed distribution of membership across plans and ages.

10. NON-BENEFIT EXPENSES, PROFIT, & RISK

The following table illustrates anticipated breakdown of the retention components. It should be noted that the administrative expenses below reflect that CHLIC is pricing to scalable membership. Hence, these expenses reflect the PMPM amount that will be incurred if CHLIC attains scale, which is not anticipated for the rating period. Actual expenses on both a PMPM and percentage of premium basis will vary based on the actual size and distribution of membership by age and plan.

Retention Component	% of Premium
Administrative Expense	8.9%
Profit Margin	2.5%
Taxes & Fees (including ACA expenses)	6.7%
Total Retention	**18.1%**

a. Administrative Expense Load

CHLIC's non-medical expenses are split out as follows:

- Acquisition admin expense – this includes, but is not limited to, incentive compensation & salaries for brokers and agents, commissions†, marketing costs (working media & non-working media), and vendor fees.
- Recurring admin expense – this includes, but is not limited to, costs relating to customer analytics, service operations, account management, and corporate overhead.

The administrative expense load is based on internal estimates from CHLIC's Financial Analysis team and is deemed appropriate for the plans proposed in this filing. To determine this load, membership for CHLIC's benefit plans is projected as outlined in Section 15.

This membership is then applied to known budgeted amounts for administrative expenses to determine a PMPM amount across all plans. The percentage load for administrative expenses varies by plan as the PMPM value represents a higher proportion in plans with lower premiums. Based on the projected enrollment, this load is expected to be 8.9% as shown above. In the event that actual membership size and distribution differs from expectations, this figure may vary.

† Commissions vary based on distribution channel. Since premium rates for plans must be the same across all channels, CHLIC has socialized its commissions based on expected membership distribution by acquisition type. CHLIC expects its exchange customers to be referred through a blend of all distribution channels (i.e. broker, direct to consumer, etc.) and purely via the Exchange without any external referral. Hence, the commissions for the Exchange channel are calculated as a weighted average of these acquisition types.

b. Profit & Risk Margin

CHLIC has targeted a 2.5% profit margin that is built into its premium rates. This target is based on CHLIC attaining scalable membership, which is not expected for the rating period. In the event that actual membership size and distribution differs from expectations, the actual profit margin may vary. There is no additional risk margin load.

c. Taxes & Fees

Please note that the TRP fee has been included in Section 9b with the projected reinsurance recoveries and has not been included in the taxes & fees shown in this section.

- Premium Tax for the State of Tennessee is applied as 1.75% of premium
- Exchange User Fee is applied as 2.80% of premium‡ PCORI Fee is applied as $2.00 PMPY
- Health Insurer's Fee is applied as 2.20% of premium
- Risk Adjustment User Fee is applied as $1.00 PMPY

‡ Exchange User Fees are applied as an adjustment to the index rate at the market level. Hence, the 3.50% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the 2.80% expected fee.

11. PROJECTED LOSS RATIO

The projected 2014 PPACA MLR, without adjustment for credibility, for CHLIC individual products is 82.30%.
A demonstration of projected MLR is illustrated below:

PPACA 2014 MLR			
1	Member Months	$	30,951
2	Incurred Claims	$	8,280,440
3	Claims Adjustment*	$	(962,601)
4	**Numerator (2 + 3)**	**$**	**7,317,839**
5	Earned Premium	$	9,056,732
6	Premium Adjustment**	$	(165,601)
7	**Denominator (5 + 6)**	**$**	**8,891,131**
8	Credibility Factor		5.15%
9	Avg Deductible Factor		131.90%
10	Credibility Adjustment (8 x 9)		6.80%
11	**PPACA MLR w/o Credibility (4 ÷ 7)**		**82.30%**
12	PPACA MLR w/ Credibility (10 + 11)		89.10%

* Quality Improvement Activities, Traditional Reinsurance Receipts, Net Risk Adjustment & Risk Corridor Receipts
** Premium/Payroll/Federal Income Tax and ACA Fee Adjustments

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell X47 in Worksheet 1 of the Part 1 URR Template.
- Incurred Claims – projections for incurred claims are developed by applying the anticipated loss ratio before reinsurance recoveries to the projected earned premium.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2014 (Final Rule)
- Earned Premium – projections for earned premium are developed by applying the projected average rate PMPM from Cell F80 in Worksheet 2 of the Part 1 URR Template to the expected member months projections specified earlier.
- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2014 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

12. INDEX RATE

The Index Rate for the Projection Period identified in Worksheet 1, Section 3, of the Part 1 URR Template was generated using the same methodology as used in determining the Single Risk Pool Gross Premium Average Rate (PMPM) in Cell V43 of Worksheet 1 in the Part 1 URR Template. Hence, the Projected Index Rate is a representation of the expected Allowable Claims PMPM for 2014 and it incorporates the impact of trend, benefit, and demographic differences. Furthermore, there are no benefits in excess of EHBs that are being covered under the proposed plans in 2014. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing and we do not plan to offer them in 2014.

As mentioned earlier, CHLIC is not expecting risk adjustment to have an impact on its index rate as we anticipate the net impact of transfer payments across plans to be negligible across the entire portfolio. The index rate has also been adjusted for net recoveries resulting from the reinsurance program. This equates to an impact of $28.82 PMPM on the index rate.

It should be noted that only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the projected index rate to arrive at each plan-level rate:

- The AV of the plan
- The cost-sharing design of the plan
- The plan's provider network, delivery system characteristics, and utilization management practices
- Administrative costs, excluding Exchange user fees

The derivation of the plan level rate from the index rate is illustrated in Section 14 below.

13. AV METAL VALUES

The AV Metal Values shown in Worksheet 2 of the Part 1 URR Template were based entirely on the AV Calculator, with the exception of the following benefits:

- Cost Sharing for Pharmacy Generic Drugs
- Cost-Sharing for Pharmacy Retail vs. Home-Delivery Service
- Limited Specialist Copays (for benefit plans with limited specialist office visits)

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). This alternate methodology and the reason for its use is explained in the accompanying actuarial certification titled "Unique Plan Design Supporting Documentation & Justification".

14. AV PRICING VALUES

Pricing AV represents the cost to CHLIC of providing coverage under each plan (incurred claims & administrative costs) as a percentage of the cost of providing coverage for a fixed reference plan. The fixed reference plan, in this case, is selected as Plan 99248TN0020007.

A demonstration of how the Pricing AV's are derived from the Metal AV's is shown below:

Derivation of Pricing AV from Metal AV							
	Plan ID						
	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Metal AV	58.2%	60.3%	68.4%	69.1%	69.4%	78.6%	80.6%
Benefits Additional to EHBs	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Impact of Provider Network	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Admin Costs (excluding Exchange User Fee)	1.01	1.01	1.00	1.00	1.00	0.99	0.98
Impact of Cost-Sharing Design	0.98	0.98	1.00	0.98	1.01	1.01	1.05
Adjusted AV	57.6%	59.4%	68.2%	67.5%	69.9%	78.2%	82.8%
Pricing AV	69.6%	71.8%	82.4%	81.6%	84.4%	94.4%	100.0%

- It should be noted that although "Impact of Provider Network" is shown as having no impact in the calculation above, the preceding table illustrates an average across the entire state. Hence, premium rates may vary between rating areas within the state as a result of differences in medical costs and provider contracts, which is not reflected above. Nevertheless, there is no impact due to provider network by benefit plan as there is no variation in provider network or delivery systems across plans, only by area.
- "Admin costs" are calculated on a PMPM and percentage of premium basis and, thus, may vary as a percentage of premiums across plans. Consequently, that impact is captured in the table above.
- The "Impact of Cost Sharing Design" corresponds to differences in utilization patterns for service categories between the AV Calculator and the data underlying the derivation of the Manual Rate. This difference was estimated by running the proposed plan designs through the AV Calculator (using its standard continuance tables) and then through CHLIC's pricing model with the CPD that serves as the underlying dataset for derivation of the Manual Rate. The difference between the two approaches was then subsequently quantified.

CHLIC is not incorporating any impact of different morbidity or health status of individuals who select certain plans in the derivation of the Pricing AV from the Metal AV.

The Adjusted AV represents the impact of applying the allowable modifiers to the Metal AV, which is shown in the table above. The Pricing AV demonstrates the relationship of the Adjusted AV between each respective plan and the reference plan, Plan 99248TN0020007.

15. MEMBERSHIP PROJECTIONS

The membership projections for CHLIC's benefit plans are developed internally as best estimates generated by applying CGLIC's current market share percentages to the addressable market opportunity developed by an SOA sponsored study, "Cost of the Future Newly Uninsured under the Affordable Care Act (ACA)". There have been additional adjustments made to take into account specific market strategies including the anticipated impacts of the new networks developed by CHLIC.

For Silver metal plans, the projected enrollment subject to cost-sharing reduction subsidies at each level is developed based on the Distribution of Population by FPL as outlined in the SOA sponsored study, "Design & Implementation Considerations of ACA Risk Mitigation Programs". CHLIC applied adjustments to the results of the study to account for expected differences in the general population and anticipated covered population that are outlined below:

- It is assumed that not all individuals above the 250% FPL level will buy silver plans, as some of them may opt for benefit plans on a different metal tier.
- Since Tennessee has opted for expansion of its Medicaid program, only the 139%-150% FPL bracket was considered when developing an estimate for the population that will enroll in the 94% Silver CSR plan.
- The study mentioned above did not split out the 200%-299% FPL bracket. For purposes of this calculation, it was assumed that the population is uniformly distributed within that bracket. Hence, 50% of the 200%-299% FPL bracket was assumed to fall in the 200%-250% FPL bracket and, thus, be eligible for the 73% Silver CSR plan.

The resulting projected enrollment by plan and subsidy level is outlined below:

Distribution by Plan by CSR-Level				
Plan ID	**139%-150% FPL**	**150%-200% FPL**	**200%-250% FPL**	**>250% FPL**
99248TN0020003	6%	25%	20%	49%
99248TN0020004	6%	25%	20%	49%
99248TN0020005	6%	25%	20%	49%

16. TERMINATED PRODUCTS

The following benefit plans will be terminated as of 1/1/2014 and will no longer be available for new sales. It should be noted that there is no membership on any of these plans as of today. As these plans do not have Component Plan IDs, we have shown "0000" for this field in the URR Template Worksheet 2.

- Open Access 2000
- Open Access 3000
- HIPAA 2000
- HIPAA 3000

17. PLAN TYPE

All plans in this filing are categorized as PPO plans.

18. WARNING ALERTS

Cell A82 – This cell shows a "Warning", indicating that the Total Premium built up on Wksh 1 – Market Experience does not equal the Total Premium on Wksh 2 – Plan Product Info. Internally, we do not build up our rates in the exact same manner as in Wksh 1, so while the premiums are similar, they will not be exactly equal. However, as can be seen in cells B80 and F80 the premiums PMPM are within 2% of each other. Wksh 2 forces the projected member months (row 47) to be rounded, so even if the premiums were identical, instead of within 2% of each other, there would still be a "Warning" displayed in cell A82.
Cell A86 – We believe the formula in cell B86 is incorrect, as B86 calculates allowed premiums net of reinsurance and risk adjustment, whereas the instructions indicate this number should be gross of reinsurance and risk adjustment. If we change the calculations in row 86 to be net of reinsurance and risk adjustment, cell A86 will display "Ok"; however, doing so will cause an error in cell A99, which looks at the Allowed Claims PMPM gross of reinsurance and risk adjustment.

19. EFFECTIVE RATE REVIEW INFORMATION

a. Financial Information

Cigna Health & Life Insurance Company (CHLIC)				
($ Millions)	**2010**	**2011**	**2012**	**2013 (Proj)**
Stat Capital & Surplus *[Pg 3, Line 38]*	**51**	**543**	**1,018**	**1,933**
Authorized Control Level RBC	**3**	**44**	**172**	**366**

CHLIC is in strong financial condition. The YE 2012 ACL RBC ratio was 605%. In prior years when the Company was significantly smaller, the RBC ratio was much higher. For the next few years, we expect to maintain an ACL RBC ratio in the 500% to 600%

range. The proposed plans and rates will have an immaterial impact on the company's financial condition, even with significant membership growth.

b. Rating Information

Premium rating rules as per PPACA have been adhered to. CHLIC is only adjusting premium rates for the following factors:

- Age – the Federal Age Slope as prescribed by HHS is used to determine rates by age.
- Area – rates vary by prescribed rating areas as shown in the rates template.
- Tobacco – rates vary by tobacco usage, but not by more than a 1.5:1 ratio as shown in the rates template.
- Family size – A maximum of 3 dependents under the age of 21 will be used to determine a rate for a family policy as shown in the business rules template.

To see the proposed rate manual by age, area and tobacco user status please reference the accompanying Rate Template. For other rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying PlansBenefits Template.

Please note that CHLIC shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit and a standalone exchange-certified pediatric dental policy.

c. Other

CHLIC's anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is 80%.

20. RELIANCE

In preparing the Part 1 Unified Rate Review Template submission, I have relied on data and analysis provided by Mitchell Pawlowski. In addition, I have relied on external sources in order to develop the underlying assumptions for the development of the proposed premium rate. These sources are outlined below:

- Clark, A. (FSA, MAAA), & O'Connor, J. T. (FSA, MAAA).
  Design and Implementation Considerations of ACA Risk Management Programs.
  Society of Actuaries (2012)
- Haught, R., & Ahrens, J.
  Cost of the Future Newly Insured under the Affordable Care Act (ACA).
  Society of Actuaries (2012)

21. ACTUARIAL CERTIFICATION

I, Lauren Danziger, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify, to the best of my knowledge and judgment, that:

a) The rates proposed in the above noted rate filing are
   - In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
   - Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
     - ASOP #5, Incurred Health & Disability Claims
     - ASOP #8, Regulatory Filings for Health Plan Entities
     - ASOP #12, Risk Classification
     - ASOP #23, Data Quality
     - ASOP #25, Credibility Procedures Applicable to Accident & Health, Group Term Life, and Property & Casualty Coverages
     - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
     - ASOP #41, Actuarial Communications
   - Reasonable in relation to the benefits provided and the population anticipated to be covered and that the rates are not excessive, inadequate or unfairly discriminatory

b) Plan level rates were generated using only the index rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)

c) The percent of total premium that represents essential health benefits included in Worksheet 2, Section IV, of the Part 1 URR Template was calculated in accordance with applicable Actuarial Standards of Practice

d) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans, save the exceptions shown in Section 13 and which are further explained in the accompanying actuarial certification "Unique Plan Design Supporting Documentation & Justification".

Lauren Danziger

June 13, 2013
Date

Lauren Danziger, FSA, MAAA
Actuarial Manager
Cigna Health & Life Insurance Company
Lauren.Danziger@Cigna.com

Data Collection Template

Company Legal Name: **Cigna Health and Life Insuranc** State: **TN**
HIOS Issuer ID: **99248** Market: **Individual**
Effective Date of Rate Change(s): **01/01/2014**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 01/01/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$6	$0.89	100.00%
Incurred Claims in Experience Period	$5	0.67	75.00%
Allowed Claims:	$7	1.00	112.50%
Index Rate of Experience Period		$1.00	
Experience Period Member Months	7		

Section II: Allowed Claims, PMPM basis

Projection Period: 01/01/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	2,000.00	$1.00	$0.17	1.000	1.000	1.000	1.000	2,000.00	$1.00	$0.17	92.28	$13,003.74	$100.00
Outpatient Hospital	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	394.74	1,987.15	65.37
Professional	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	6677.06	150.69	83.85
Other Medical	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	2095.42	406.13	70.92
Capitation	Services	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	1.00	1.00	0.00
Prescription Drug	Prescriptions	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	8219.83	88.24	60.44
Total				$1.00							$1.00			$380.58

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$380.58	$11,779,273
Paid to Allowed Average Factor in Projection Period			0.716	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$272.54	$8,435,273
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$272.54	$8,435,273
Projected ACA reinsurance recoveries, net of rein prem, PMPM			28.82	891,916
Projected Incurred Claims			$243.72	$7,543,356
Administrative Expense Load		8.88%	26.43	818,151
Profit & Risk Load		2.50%	7.44	230,322
Taxes & Fees		6.74%	20.07	621,063
Single Risk Pool Gross Premium Avg. Rate, PMPM			$297.66	$9,212,893
Index Rate for Projection Period			$380.58	
% increase over Experience Period			33386.82%	
% Increase, annualized:			1729.94%	
Projected Member Months				30,951

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**Cigna Health and Life Insurance Company**	State:	**TN**
HIOS Issuer ID:	**99248**	Market:	**Individual**
Effective Date of Rate Change(s):	**01/01/2014**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		OAP	LocalPlus						
Product ID:		99248TN001	99248TN002						
Metal:		Catastrophic	Bronze	Bronze	Silver	Silver	Silver	Gold	Gold
AV Metal Value		0.000	0.582	0.603	0.684	0.691	0.694	0.786	0.806
AV Pricing Value		0.001	0.696	0.718	0.824	0.816	0.844	0.944	1.000
Plan Type:		PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name		Terminated Products	myCigna Health Savings 6100	myCigna Health Flex 5500	myCigna Health Savings 3400	myCigna Health Flex 1500	myCigna Health Flex 5000	myCigna Health Flex 1900	myCigna Health Flex 1250
Plan ID (Standard Component ID):		99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Exchange Plan?		No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%						
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%						
Historical Rate Increase - Calendar Year 0		0.00%	0.00%						
Effective Date of Proposed Rates		01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	32819.21%	32819.21%	32819.21%	32819.21%	32819.21%	32819.21%	32819.21%
Product Threshold Rate Increase %		#DIV/0!	0.00%						

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Inpatient	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Outpatient	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Professional	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Prescription Drug	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Other	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Capitation	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Administration	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Taxes & Fees	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Risk & Profit Charge	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Total Rate Increase	$9.00	$0.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Average Current Rate PMPM	$292.62	$0.00	$292.62	$292.62	$292.62	$292.62	$292.62	$292.62	$292.62
Projected Member Months	30,954	0	4,422	4,422	4,422	4,422	4,422	4,422	4,422

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Average Rate PMPM	$0.89		$0.89	$0.89	$0.89	$0.89	$0.89	$0.89	$0.89
Member Months	7		1	1	1	1	1	1	1
Total Premium (TP)	$6	$0	$1	$1	$1	$1	$1	$1	$1
EHB basis or full portion of TP, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$7		$1	$1	$1	$1	$1	$1	$1
EHB basis or full portion of TAC, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$2		$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Incurred claims, payable with issuer funds	$5	$0	$1	$1	$1	$1	$1	$1	$1
Net Amt of Rein	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	$0.67	#DIV/0!	$0.67	$0.67	$0.67	$0.67	$0.67	$0.67	$0.67
Allowed Claims PMPM	$1.00	#DIV/0!	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
EHB portion of Allowed Claims, PMPM	$1.00	#DIV/0!	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Average Rate PMPM	$292.62	$0.00	$292.62	$292.62	$292.62	$292.62	$292.62	$292.62	$292.62
Member Months	30,954	-	4,422	4,422	4,422	4,422	4,422	4,422	4,422
Total Premium (TP)	$9,057,610	$0	$1,293,944	$1,293,944	$1,293,944	$1,293,944	$1,293,944	$1,293,944	$1,293,944
EHB basis or full portion of TP, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$11,780,415		$1,682,916	$1,682,916	$1,682,916	$1,682,916	$1,682,916	$1,682,916	$1,682,916
EHB basis or full portion of TAC, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$4,236,328		$605,190	$605,190	$605,190	$605,190	$605,190	$605,190	$605,190
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$415,551		$59,364	$59,364	$59,364	$59,364	$59,364	$59,364	$59,364
insured person, as %	9.81%	#DIV/0!	9.81%	9.81%	9.81%	9.81%	9.81%	9.81%	9.81%
Total Incurred claims, payable with issuer funds	$7,544,087	$0	$1,077,727	$1,077,727	$1,077,727	$1,077,727	$1,077,727	$1,077,727	$1,077,727
Net Amt of Rein	$892,003		$127,429	$127,429	$127,429	$127,429	$127,429	$127,429	$127,429
Net Amt of Risk Adj	$0		$0	$0	$0	$0	$0	$0	$0

1. HIOS Issuer ID:

99248

2. HIOS Product ID(s):

99248TN002

3. Applicable HIOS Plan ID(s) (Standard Component):

99248TN0020001
99248TN0020002
99248TN0020003
99248TN0020004
99248TN0020005
99248TN0020006
99248TN0020007

4. Reasons the Plan Design is Unique and not compatible with AV Calculator Parameters:

In this section we have provided a description of the features of the plan designs that are considered unique and not compatible with the AV Calculator parameters along with a table that outlines which plans have these features.

The following features of the plan design(s) are considered unique and not compatible with AV Calculator parameters:

- Pharmacy Generic Drugs – The plans proposed in this filing have a five-tier pharmacy benefit design as opposed to the four-tier design that the AV Calculator can accept. Tiers 1 and 2 on the CHLIC plans divide the generic tier into two buckets and then tiers 3, 4 and 5 correspond to tiers 2, 3 and 4 in the calculator. Since the AV Calculator only allows for four tiers on the pharmacy benefit design, an alternative methodology was deemed necessary.

- Cost-Sharing for Pharmacy Retail vs. Home Delivery Service – The proposed plans in this filing offer Home Delivery pharmacy prescriptions in addition to retail pharmacy prescriptions. Since the AV Calculator does not allow for separate cost share inputs for retail and home delivery pharmacy prescriptions, the cost share for the pharmacy benefit was not compatible with the existing parameters of the AV Calculator.

- Limited Specialist Copays – The AV Calculator provides the option of applying deductible & coinsurance to primary care visits after a limited number of PCP visits subject to copays. However, it does not provide a similar option for specialist visits. Some of the plans proposed in this filing include a benefit design feature that applies deductible & coinsurance to specialist visits after a limited number of SCP visits are subject to copays. Hence, such plans cannot be valued directly with the existing parameters of the AV Calculator.

The following table illustrates which benefit plans contain these unique plan design features:

	Unique Plan Feature		
Plan ID	Generic Rx	Rx Retail vs Home-Delivery	Limited Specialist Copays
99248TN0020001	✓	✓	
99248TN0020002	✓	✓	✓
99248TN0020003	✓	✓	
99248TN0020004	✓	✓	✓
99248TN0020005	✓	✓	
99248TN0020006	✓	✓	
99248TN0020007	✓	✓	

5. Acceptable Alternate Method used per 156.135(b)(2) or 156.135(b)(3):

In order to quantify the Actuarial Value of each unique plan feature, the following two methods were employed:

- In line with the proposed methodology of 156.135(b)(2), an estimate of the plan design feature was fitted into the AV Calculator to align with the Calculator's existing input parameters.
- In line with the proposed methodology of 156.135(b)(3), if certain plan features did not fit within the AV Calculator's existing input parameters, the AV for those unique plan features was valued outside of the AV Calculator. This adjustment was then appropriated to the AV calculated within the AV Calculator for all plan provisions that did fit within the AV Calculator parameters.

The following table illustrates which Alternate Method was used to address each unique plan feature:

	Unique Plan Feature		
Method Used:	Generic Rx	Rx Retail vs Home Delivery	Limited Specialist Copays
156.135(b)(2)	✓	✓	
156.135(b)(3)			✓

6. Confirmation that only In-Network Cost Sharing was considered:

For the purpose of quantifying the Actuarial Value of each unique plan design, only In-Network cost sharing was brought into consideration. CHLIC did not account for Out-Of-Network cost sharing during this process.

7. Description of Standardized Plan Population Data used:

The standardized plan population data used for calculating the AV of plans with the Generic Rx, Rx Retail vs. Home Delivery and Limited Specialist Copays unique plan features is the default standard population developed by HHS for AV calculation and provided as an underlying assumption to the Continuance Tables in the AV Calculator. In addition, for the pharmacy unique plan design features, as discussed in Section 8, internal national group experience was used in order to develop the inputs entered into the AV Calculator.

8. If 156.135(b)(2) was used, describe how benefits were modified to fit AV Calculator:

Pharmacy Generic Drugs – In order to use the AV calculator, we have blended the cost-sharing for tiers 1 & 2 outside of the tool based on expected utilization patterns and average costs per prescription for these tiers to calculate a single copay or coinsurance percentage that can be entered into the AV calculator for Tier-1.

Cost-Sharing for Pharmacy Retail vs. Home Delivery Service – The cost-sharing for each tier was blended prior to being input in the AV Tool based on expected utilization patterns for retail pharmacy services as opposed to home delivery pharmacy services.

9. If 156.135(b)(3) was used, describe method(s) and data used to develop adjustments:

Limited Specialist Copays - Each plan design with the Limited Specialist Copay plan feature was run in the Actuarial Value Calculator (AVC) with unlimited specialist copays and an adjustment that ranges from -0.5% to -0.1% was applied to calculate the final AV. To determine the necessary adjustments, the AVC and specifically the AVC's methodology for valuing the impact of limiting PCP office visits was utilized.

In general, the AV of a plan that covers a limited number of specialist office visits subject to copays and subsequent visits under deductible/coinsurance falls between the AV produced by the AVC for a plan with unlimited visits with the indicated specialist copay and the AV produced by the AVC for a plan with deductible and coinsurance on specialist visits.

Relativities among the AVs, as determined by the AVC, for benefit plan designs with unlimited PCP visit copays, limited PCP visit copays, and PCP visit under deductible/co-insurance were utilized to calculate the final adjustments. Please note that none of the adjustments cause the plan AVs to fall outside their metal threshold.

10. Certification Language:

The development of the actuarial value is based on one of the acceptable alternative methods outlined in 156.135(b)(2) or 156.135(b)(3) for those benefits that deviate substantially from the parameters of the AV Calculator and have a material impact on the AV.

The analysis was

(i) conducted by a member of the American Academy of Actuaries; and
(ii) performed in accordance with generally accepted actuarial principles & methodologies.

Lauren Danziger

Lauren Danziger, FSA, MAAA
Actuarial Manager
Cigna Health & Life Insurance Company

4/18/2013
Date

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

myCigna Health Savings 6100

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,100.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☐	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.2%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

myCigna Health Flex 5500

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

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Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	60.8%	**60.3% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Bronze	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Savings 3400

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,400.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Savings 3400 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,600.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.2%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Savings 3400 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.6%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Savings 3400 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$350.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.3%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Flex 1500

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.48	☑	☑		
Preferred Brand Drugs	☐	☐		$58.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	69.1%	**69.1% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Silver	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Flex 1500 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.48	☑	☑		
Preferred Brand Drugs	☐	☐		$58.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.	
Actuarial Value:	72.6%	**72.5% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Silver	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Flex 1500 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$725.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$1,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.	
Actuarial Value:	86.3%	**86.3% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Gold	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Flex 1500 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$575.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$8.23	☑	☑		
Preferred Brand Drugs	☐	☐		$19.33	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.	
Actuarial Value:	93.5%	**93.4% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Platinum	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Flex 5000

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Flex 5000 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Flex 5000 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,450.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Flex 5000 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$8.23	☑	☑		
Preferred Brand Drugs	☐	☐		$19.33	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

myCigna Health Flex 1900

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.6%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

myCigna Health Flex 1250

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.6%
Metal Tier:	Gold

Business Rules Template v1.5

To validate the template, press Validate button or Ctrl + Shift + V. To finalize the template, press Finalize button or Ctrl + Shift + F.

Enter the Issuer Rule on the first row (no Product ID or Plan ID).

For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.

For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule

HIOS Issuer ID*	99248
TIN*	59-1031071

Product ID	Plan ID (Standard Component)	How are rates for contracts covering two or more enrollees calculated?	What are the maximum number of under age (under 21) dependents used to quote a two parent family?	What are the maximum number of under age (under 21) dependents used to quote a single parent family?	Is there a maximum age for a dependent?	What are the maximum number of children used to quote a children only contract?	Are domestic partners treated the same as secondary subscribers?	Are same-sex partners treated the same as secondary subscribers?	How is age determined for rating and eligibility purposes?	How is tobacco status determined for subscribers and dependents?	What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
		A different rate (specifically for parties of two or more)for each enrollee is added together	3 or more	3 or more	25	3 or more	No	No	Age on effective date	6	Adopted Child, No; Brother or Sister, No; Child, No

CIGNA HealthCare
PO Box 30365
Tampa FL 33630-3365

Policy Specification Page

[Policy Name]
Benefit Option Code: [XXXX]

Insured:	[First, Last]		
Identification Number:	[XXXXXXXXX]	Policy Effective Date:	[mm/dd/yyyy]
Form Number:	**INDTNCH~~1~~0420120~~2~~3**	Plan Number	[XXXXXX]
Benefit Option Code:	[XXXX]	Annual Deductible	[$XXX]

This Policy Specification Page is part of and incorporated into the Policy identified by the Identification Number and Form Number shown above.

[This Policy is generally subject to a preexisting condition exclusion that runs 12 months from the effective date. This exclusion period may be reduced by qualified creditable coverage from your prior health plan. Listed below for each Insured Person is the preexisting Condition End Date as determined from the information we may have received regarding your creditable coverage.

If you disagree with the amount of coverage with which you are being credited, please submit an additional evidence of creditable coverage to CIGNA at the above listed address.]

INSURED PERSON(S) UNDER THIS PLAN

Name	Original Effective Date	Preexisting Condition End Date	Monthly Premium
[xxxxxxxxxxxxxxxx]	[xxxxxxxxxxxxxxxxx]	[xxxxxxxxxxxx]	[xxxxxxxxxxx]

Signed for CIGNA by:

Shermona Mapp, Corporate Secretary

[SUBSCRIBER NAME]
[ADDRESS]
[CITY STATE ZIPCODE] [BENEFIT OPTION CODE]

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[Tennessee] [Plan Name][s]

~~[Pre-existing Condition Limitations~~

~~[For any Insured Persons age 19 and older, any services received on or within 12 months after the Effective Date of coverage **are not covered** if they are related to a **Pre-existing Condition** as defined in the Definitions section.]]~~

~~[*Remove this text for Guarantee issue HIPAA Policy's]*~~

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna~~IGNA~~ Health~~EALTH~~ And~~ND~~ Life~~IFE~~ Insurance~~NSURANCE~~ Company~~OMPANY~~ (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. If You know of any misstatement in Your application, ~~or if any information concerning the medical history of any Insured Person has been omitted,~~ You should advise the Company immediately regarding the incorrect ~~or omitted~~ 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. [Eastern time] on the Effective Date shown on the Policy's specification page.**

~~**This is not a policy of worker's compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this Policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the worker's compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.**~~

~~**Guaranteed Renewable**~~

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

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

Your medical coverage is provided under a Policy issued by Cigna~~IGNA~~ Health~~EALTH~~ ~~AND~~and Life~~IFE~~ Insurance~~NSURANCE~~ Company~~OMPANY~~ ("Cigna"). This Policy is a legal contract between You and Us.

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

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

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

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

[If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY ~~omitted~~misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any material facts that were INTENTIONALLY ~~omitted~~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 ~~give~~provide you with~~a~~ 30 days advance~~d~~ notice and We will refund all premiums You ~~P~~paid for your Policy less the amount of any claims paid by Cigna. ~~you have the right to appeal any decision to rescind your coverage through the interal appeals process.~~ Rescission of Your coverage will result in denial of all pending claims and, ~~I~~if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. [You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider. [REMOVE FOR EPO/OAP-INN PLANS]][However, non-emergency services from a Non-Participating Provider are not covered by this Plan.[USE FOR EPO/OAP-INN PLANS]]

THIS IS AN [EXCLUSIVE PROVIDER][NETWORK-ONLY]PLAN
That means this Plan does not provide benefits for any services You receive from an Out-of-Network Provider except:

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

In-Network Providers include Physicians, Hospitals, and other health care facilities. Check the provider directory, available on mycigna.com, or call the number on Your ID card to determine if a Provider is In-Network. You can also ask the Provider directly.]

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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][LACK OF COVERAGE FOR THE SERVICES PROVIDED].

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. [Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.] If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE[OAP/HSP/Metal Plans VERSION]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

NOTE:
The benefits outlined in the table below show the payment for Covered Expenses. Coinsurance amounts shown below are ~~CIGNA's~~Your responsibility after any applicable [deducible][copayment][access fee][additional deductible][has][have]been met, unless otherwise indicated. Copayment amounts shown are also Your~~the INSURED PERSON'S~~ responsibility.

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	~~COINSURANCE~~ BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ~~Cigna's RESPONSIBILITY; COPAYMENT AMOUNTS ARE~~	

Medical Benefits
~~[use note in HSP Policies only]~~
~~[* NOTE:~~
~~ONLY the INDIVIDUAL Deductible and Out-of-Pocket Maximum applies when one individual is enrolled in the Plan~~
~~ONLY the FAMILY Deductible and Out-of-Pocket Maximum applies when two or more individuals are enrolled in the Plan]~~

Annual Plan Deductible~~[*]~~	**In-Network Deductible**	**Out-of-Network Deductible**
Individual	$[0-25,000]	[$[0-50,000]]~~[Not Applicable]~~
Family	$[0-50,000]	[$[0-100,000]]~~[Not Applicable]~~

[Please NoteOTE: Additional Deductibles may apply to specific benefits.]

[Additional Deductibles]

[Some services may require a deductible for that service, and be subject to the [Annual Plan Deductible. Refer to the following pages of this Benefit Schedule for benefits on specific services.]	[Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.]

Coinsurance

[The coinsurance level for ~~[PCP and]~~specialty Physician inpatient/outpatient physician services will differ between CCN and Non-CCN designated ~~[PCP and]~~specialist	[0-40]%	[0-50]%

services. The term Cigna Care Network (CCN) refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.]		
[Non-CCN PCP][Primary Care Provider (PCP)]	[Cigna pays [50-100]% of eligible charges.] [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[Cigna pays [0-100]% % of eligible charges.] [You and Your Family Members pay [0-1050]% after the Policy Deductible.]
[CCN-designated PCP]	[Cigna pays[[50-100%] of eligible charges for Physician services] [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[Not Available]
[[Non-CCN]Specialist]	[Cigna pays[[50-100%] of eligible charges for Physician services] [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	Cigna pays [0-100]% of eligible charges.] [You and Your Family Members pay [0-1050]% after the Policy Deductible.]
[CCN-designated specialist]	[Cigna pays[[50-100%] of eligible charges for Physician services] [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[Not Available]
[Other Covered Services]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]
Out-of-Pocket Maximum	**In-Network Out-of-Pocket Maximum**	**Out-of-Network Out-of-Pocket Maximum**
Individual	[$[0-30,000]] [Not Applicable]	[$[0-unlimited]] [Not Applicable]
Family	[$[0- 60,000]] [Not Applicable]	[$[0-unlimited]] [Not Applicable]
The following do not accumulate to the Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges] [and] [Mental Health] [and] [Substance Abuse charges][Charges for Infusion and Injectable Specialty Prescription Medications][Access Fees][Penalties] and Policy Maximums.	[The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.]	[The following do not accumulate to the Out-of-Network Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential Health Benefits,] [and] [Mental Health] [and] [Substance Abuse charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][Penalties] and Policy Maximums.]

Prior Authorization Program

Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed [a] $[500-$1,000], [penalty]** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed [a] $[50-$500], [penalty]** for non-compliance.
~~**[Plan Lifetime Maximum]**~~	~~[unlimited]~~	
~~***[Pre-existing Condition Limitation applies to Insured Persons age 19 and over only]***~~ ~~*[(but may be reduced by Insured Person's prior eligible Creditable Coverage. See the definition of Pre-existing Condition.)]] [Remove this text for Guarantee issue HIPAA Policy's]*~~	~~[Yes] [Remove this text for Guarantee issue HIPAA Policy's]~~ ~~[None]~~	~~[Yes] Remove this text for Guarantee issue HIPAA Policy's~~ ~~[None]~~
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	~~10~~0% Deductible waived	[0-~~10~~50]% [Deductible waived][Not Covered]
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than [19]years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	[0-50%% per exam] [Deductible waived]	[You pay all but $30 per exam] [Not Covered]
Eyeglasses and Lenses for Children	[0-50% per pair] [Deductible waived]	[Not Covered]
Frames		[You pay all but $30 per frame]
Single Vision		[You pay all but $25 per pair]
Lined Bifocal		[You pay all but $35 per pair]

Lined Trifocal or Lenticular		[You pay all but $45 per pair]
[Limited to one pair per year]		
Contact Lenses for Children	[0-50% per pair] [Deductible waived]	[Not Covered]
Elective		[You pay all but $75 per pair]
Therapeutic		[You pay all but $225 per pair]
[Limited to one pair per year]		
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit		
Physician Services		
[Primary Care Physician (PCP) services]	[(No Referral Required)]	
[Services of a specialist[, with PCP Referral and/or Plan Authorization]	[(PCP Referral or Plan Authorization is [NOT]required)]	
Office Visit [(including [allergy testing and treatment/injections][and][lab and x-ray tests][and surgery]done in the office)]		
[Primary Care][Physician] [(PCP)] [Non-Cigna Care Designation (CCN) PCP]	[$[~~1~~0-~~1~~250] Copayment] per office visit; [[~~5~~0-~~10~~50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-~~1~~250] Copay] [all visits after the first [1-10] per Year: [~~5~~0-~~10~~50]%] [visits [2-10]-[3-15] per Year: [50-100]%] [visits over [5-15] per Year: [50-100]%]	[0-~~10~~50]% [Not Covered]
[Primary Care Physician (PCP) with CCN designation] ~~[Cigna Care Designation (CCN) PCP]~~	[$[~~1~~0-2~~0~~50] Copayment] [per office visit] [[~~5~~0-~~10~~50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-2~~0~~50]Copay] [all visits after the first [1-10] per Year: [~~5~~0-~~10~~50]%] [visits [2-10]-[3-15] per Year: [~~5~~0-~~10~~50]%] [visits over [5-15] per Year: [~~5~~0-~~10~~50]%]	[Not Available]
Specialist, (including consultant, referral and second opinion services)[, **with PCP Referral and/or**	[$[~~1~~0-2~~0~~50] Copayment] [per office visit]	[[0-~~10~~50]%] [Not Covered]

Plan Authorization][Cigna Care Designation (CCN) Specialist]	[[50-1050]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-2050]Copay] [all visits after the first [1-10] per Year: [50-1050]%] [visits [2-10]-[3-15] per Year: [50-1050]%] [visits over [5-15] per Year: [50-1050]%]	
[Specialist, (including consultant, referral and second opinion services) **with CCN designation [, with PCP Referral and/or Plan Authorization]]**[[Non-Cigna Care Designation (CCN)] Specialist Physician (including consultant, referral and second opinion services)]	[$[10-2050] Copayment][per office visit] [[50-1050]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200] Copay] [all visits after the first [1-10] per Year: [50-100]%] [visits [2-10]-[3-15] per Year: [50-1050]%] [visits over [5-15] per Year: [50-1050]%]	[Not Available]
[NoteOTE: Iif a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed [with a Cigna Care Designation, Your or Your Family member will pay the CCN specialist copay. If your doctor is listed] as a [non-CCN] specialist, You or Your Family Member will pay the [non-CCN] specialist Copayment.]		
Physician Services, continued		
[Surgery in Physician's office]	[[50-1040]%]][included in Office Visit copayment] [Deductible waived]	[[0-1050]%] [Not Covered]
[Outpatient Professional Fees for Surgery] [(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy]	[[50-1040]%] [included in outpatient facility copayment] [Deductible waived]	[[0-1050]%][Not Covered]
[Inpatient] Surgery, Anesthesia, Radiation Therapy[, Chemotherapy]		[[0-1050]%][Not Covered]
In-hospital visits	[50-1040]% [Deductible waived]	[[0-1050]%][Not Covered]
[Allergy testing and treatment/injections]	[50-1040]% [Deductible waived]	[[0-1050]%][Not Covered]
	[[50-1040]%] [included in Office Visit copayment] [Deductible waived]	
Hearing Aids for children through age 18 **Maximum one hearing aid per ear, every 3 years up to a maximum of $1,000.**	[[50-1050]%]	[0-1050]% [Not Covered]

Note: Services necessary to select, fit and adjust the hearing aid are included in the benefit ~~maximum amount of $1,000~~.

Hospital Services

Inpatient Hospital Services [Facility Charges]	[$[500-5,000] Additional Deductible per admission, then][[~~5~~0-~~10~~50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	[$[500-5,000] Additional Deductible per admission, then][[0-~~10~~50]%] [Not Covered]
[Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][~~5~~0-~~10~~50]%] [Included in facility per-day copayment]	[$[500-5,000] Additional Deductible per admission, then][[0-~~10~~50]%] [Not Covered]
Emergency Admissions [Facility Charges]	[$[500-$1,5,000] Additional Deductible per admission, then][~~5~~0-~~10~~50%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	In-Network benefit level until transferable to an Participating In-Network Hospital then [[0-~~10~~50]%][Not Covered]
[Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][[~~5~~0-~~10~~50]%] [Included in facility per-day copayment]	[In-Network benefit level until transferable to an In-Network Hospital then [[0-~~10~~50]% [Not Covered]
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[~~5~~0-~~10~~50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[0-~~10~~50]%] [to a maximum payment of $[500-1,500] per [service][visit][admission]] [Not Covered]

Emergency Services

Emergency Room	[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]][[~~5~~0-~~10~~50]%]]	In-network benefit level for an ~~E~~emergency ~~M~~medical ~~C~~condition, otherwise [[$[50-~~1~~500] ~~[Copayment]~~[Access Fee, waived if admitted]per visit [then]][[~~5~~0-~~10~~50]%]]
Ambulance [emergency transportation [to the nearest facility][capable of handling the emergency][only.]]	[~~5~~0-~~10~~50]%[for [Ground][or]Air][transport].	In-network benefit level for an ~~E~~emergency ~~M~~medical ~~C~~condition, otherwise [[0-~~10~~50]%] [for [[Ground][or][Air]transport].
Urgent Care	[$[25-250] Copayment per visit] [then] [[~~5~~0-~~10~~50]%]	In-network benefit level for an ~~E~~emergency ~~M~~medical ~~C~~condition, otherwise [$[25-250] Copayment per visit] [then] [[0-~~10~~50]%]

Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[[~~5~~0-~~10~~50]%] [MRI:] [MRA:] [PET:] [CT Scan:] [Nuclear Medicine:] [$[100-1,000] Copayment per scan]	[[0-~~10~~50]%] [Not Covered]
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	[$[0-2~~0~~50] Copayment] [[~~5~~0-~~10~~50]%][~~Included in~~Subject to PCP/specialist office visit ~~Copay~~benefit] [~~Cigna pays 10~~0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [~~5~~0-~~10~~50]%][After Deductible][Deductible waived]	[[0-~~10~~50]%] [Not Covered]
Free-standing/Independent lab or x-ray facility	[[~~5~~0-~~10~~50]%] [Deductible waived] [~~Cigna pays 10~~0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office/Outpatient X-Ray/Lab Facilities] [then] [~~5~~0-~~10~~50]%][After Deductible][Deductible waived]	[[0-~~10~~50]%] [Not Covered]
Outpatient hospital lab or x-ray	[[~~5~~0-~~10~~50]%] [~~Cigna pays 10~~0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent/ X-Ray/Lab Facilities] [then] [~~5~~0-~~10~~50]%][After Deductible][Deductible waived]	[[0-~~10~~50]%] [Not Covered]
Short-Term Rehabilitative Services [Physical,] [Occupational,] [Speech,][and Chiropractic] [Therapy] [Acupuncture][/Acupressure] [Maximum of [10-40] ~~[days] [~~visits~~]~~ per Insured Person, per calendar year, ~~for all~~per therapy~~ies~~, In- and Out-of-Network combined.] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[$[0-2~~0~~50] Copayment] [PCP][or][specialist office visit benefit applies]~~Copayment]~~ [[~~5~~0-~~10~~50]%] [All except [$10-$50] ~~maximum payment~~ Per Insured Person, per visit.]	[0-~~10~~50]% [Not Covered] [All except [$10-$50] ~~maximum payment~~ Per Insured Person, per visit.]
Cardiac & Pulmonary Rehabilitation [Maximum of [25-60] ~~[days]~~ [visits] per	[~~5~~0-~~10~~50]% [$[10-200] Copayment] [[PCP	[[0-~~10~~50]%][All except$[10-50] per visit]

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Insured Person, per calendar year, per therapy, In- and Out-of-Network combined] [Limits based on Medical Necessity guidelines]	][or][specialist office visit benefit applies][per visit] [All except$[10-50] per [day] [visit].]	[Not Covered]
[Acupuncture][/Acupressure] [Maximum of [10-40] ~~[days]~~ [visits] per Insured Person, per calendar year for [all therapies,][In- and Out-of-Network combined.]]	[$[0-200] Copayment] [PCP][or][specialist]~~Copayment~~office visit benefit applies][per visit] [[50-100]%] [All except [$10-$50] ~~maximum payment~~ Per Insured Person, per visit.]	[[0-~~10~~50]%] [All except [$10-$50] ~~maximum payment~~ Per Insured Person, per visit.] [Not Covered]]
~~[~~Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD) ~~[Maximum of $[500-unlimited] per Insured Person per calendar year, In- and Out-of-Network Combined]~~	[~~5~~0-~~10~~50]%	[[0-~~10~~50]%] [Not Covered]]
Habilitative Services Including **[Physical,] [Occupational,] [Speech] [Therapy]** [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined.] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[0-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per visit.]	[[0-50]%] [All except $[10-50] Per Insured Person, per visit.] [Not covered]
Womens' Contraceptive Services, Family Planning and Sterilization	[No charge, no Deductible]	[[0-50]%][Not Covered]
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[[0-50]%] [Not covered]
~~**Complications of Pregnancy**~~	~~[50-100]%~~	~~[[0-100]%] [Not Covered]~~
Maternity (Pregnancy and Delivery) /Complications of Pregnancy		
Initial Office Visit to confirm pregnancy [and subsequent prenatal visits billed separately from the "global" fee]	[0-50]% [$[0-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[0-50]% [Not Covered] [[0-50]%][Not Covered]
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-50]%	[[0-50]%][Not Covered]

Hospital Delivery charges	[[$500-5000] Additional Deductible per admission, then][0-50]%	[[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered]
Prenatal testing or treatment billed separately from "global" fee	[0-50]% [Deductible waived]	[[0-50]%][Not Covered]
Postnatal visit or treatment billed separately from "global" fee	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[Not Covered]
Dental Care (other than Pediatric) Limited to treatment ~~F~~for accidental injury to natural teeth~~,~~ within ~~6~~six months of the ~~date of~~accidental injury ~~A~~Also includes anesthesia for dental procedures for a child under age 8.	[~~5~~0-~~10~~50]%	[[0-~~10~~50]%] [Not Covered]
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[~~5~~0-~~10~~50]%	[0-~~10~~50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[~~5~~0-~~10~~50]%	[0-1~~00~~5]%
Inpatient Services at Other Health Care Facilities [Including] Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities [Maximum of [20-100] days per Insured Person per calendar year ~~[~~combined In- and Out-of-Network ~~]~~for all facilities listed]	[$[500-5000] Additional Deductible per admission, then] [[~~5~~0-~~10~~50]%] [$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]	[$[500-5000] Additional Deductible per admission, then] [[0-~~10~~50]%] [Not Covered]
Home Health Services [Maximum [20- 100] [days] [visits] per Insured Person, per calendar year.] [Maximum [~~8~~4-16] hours per day] [Maximum [2-8] visits per day]	[~~5~~0-~~10~~50]%	[[0-~~10~~50]%] [Not Covered]

Durable Medical Equipment	[~~5~~0-~~10~~50]%	[[0-~~10~~50]%] [Not Covered]
Prosthetics	[0-50]%	[[0-50]%][Not Covered]
Hospice		
Inpatient	[[~~5~~0-~~10~~50]%][Inpatient Hospital Services benefit applies]	[[$500-5000] Additional Deductible per admission, then][[0-~~10~~50]%][Not Covered]
Outpatient	[[~~5~~0-~~10~~50]%][$[25-250] Copayment per [day][visit] [Deductible waived]	[[0-~~10~~50]%][Not Covered]
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	[[$500-5000] Additional Deductible per admission, then][[0-50]%]
Outpatient	[$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[[0-50]%] [Not Covered]
Autism Spectrum Disorders ~~Benefits are limited to~~[For Insured Persons ~~less than~~[under age ~~1~~2-25 only ~~years of age~~]]		
Diagnosis of Autism Spectrum Disorder		
Office Visit	[PCP or Specialist Office Visit benefit applies][$[0-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[[0-~~10~~50]%][Not Covered]
Diagnostic testing	[~~5~~0-~~10~~50]%	[[0-50]%][Not Covered]
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	Copay or Coinsurance applies for specific benefit provided	[[0-50]%][Not Covered]
[Mental, Emotional or Functional Nervous Disorders		

[Inpatient] [Maximum [5-45] days combined In- and Out-of-Network per Insured Person, per Calendar Year]	[$[500-5,000] Additional Deductible per admission, then] [[50-1050]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-50]%] [Not Covered]	[$[500-5,000] Additional Deductible per admission, then] [[0-1050]%] [Not Covered]
[Outpatient] **[Maximum [5-45] visits combined in and out of network per calendar Year per Insured Person][Maximum one visit per day]**	[$[10-2050] [copay] [PCP][specialist Office Visit benefit applies] copayment [per visit][, one visit per day] [[50-1050]%] [Deductible waived] [Visits [1-10] per Year : $[0-150]Copay] [all visits after the first [1-10] per Year: [50-100]%] [visits [2-10]-[3-15] per Year: [50-100]%]	[[0-1050]%] [Visits [1-10] per year, then [0-100]%for remaining visits per Year] [Not Covered]]
[Substance Abuse		
[Inpatient Rehabilitation] [Maximum [5- 45] days combined in and out of network per calendar year per Insured Person]]	[$[500-5,000] Additional Deductible per admission, then] [[50-1050]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [Not covered]	[[$[500-5,000] Additional Deductible per admission, then] [50-1050%] [Not Covered]
[Inpatient Detoxification [only]] [Maximum [0-60] days combined in and out of network per calendar year per Insured Person]	[$[500-5,000] Additional Deductible per admission, then] [[50-1050]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [Not Covered]	[$[500-5,000] Additional Deductible per admission, then] [[0-1050]%] [Not Covered]
[Outpatient [Maximum [5-20] visits combined in and out of network calendar year] [Maximum one visit per day]]	[one visit per day, per Insured Person.] [[50-100]%] [$[10-2050] [specialist Office Visit benefit applies] copay [per visit][, one visit per day] [Visits [1-10] per Year : $[10-200]Copay] [all visits after the first [1-10] per Year: [50-100]%] [visits [2-10] [3-15] per Year: [[50-100]%] [Not Covered]	[[0-1050]%] [Visits [1-10] per year: [0-100]% then [0-100]%for remaining visits per Year] [Not Covered]]
[Smoking Cessation] [Maximum of $[50-150] for pharmaceuticals per Insured Person] [Maximum of $[50-150] for Covered Services payable per Insured Person, for any smoking cessation program] [Maximum of [1-3] treatment programs covered per Insured Person.]	[[50-1050]%[Deductible waived]]	[[0-1050]%[Deductible waived]] [All except $[50-500] per Year for any smoking cessation program] [and][All except $[50-500] per Year for any smoking-cessation related pharmaceuticals] [Deductible waived][Not Covered]

Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)		
Cigna LIFESOURCE Transplant Network® Facility]	[$[500-5,000] Additional Deductible per admission, then] [~~5~~0-~~10~~50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]]	NOT APPLICABLE
[Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility)**]** [Travel benefit Lifetime maximum payment of $[10,000-800,000]]	[~~5~~0%-~~10~~50]%	NOT APPLICABLE
Other Cigna Network Facility	[$[500-5,000] Additional Deductible per admission, then][~~5~~0-~~10~~50]%] [$[250-2,000] Copayment per inpatient day [Limit of [3-10]days of inpatient copayments per year]][0-50%]]	NOT APPLICABLE
[Out-of-Network Facility~~]~~	~~[~~NOT APPLICABLE~~]~~	[$[500-5,000] Additional Deductible per admission, then] [0-~~10~~50]%][Not Covered] [Subject to the following limits per transplant: Heart - $150,000 Liver - $230,000 Bone Marrow -$130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas – $80,000]
[Infusion and Injectable Specialty Prescription Medications and related services or supplies	[~~5~~0-~~10~~50]%	[[0-~~10~~50]%][Not Covered~~Available~~]]

[Routine Adult Eye Exam [Limited to one routine eye exam [per Year][every 2 years]] [Limited to one pair of glasses or contact lenses [per Year][every [2-3] years]]	[Not Covered] [$[10-200 Copayment per exam] [~~10~~0% up to a maximum of $[15-100] per exam] [~~10~~0% up to a maximum of $[50-300] for frames, lenses and/or contact lenses]]	[[0-50]%] [Not Covered]]

[BENEFIT INFORMATION Note: ~~Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.~~	IN-NETWORK-YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK-YOU PAY (Based on Maximum Reimbursable Charge)
	~~COINSURANCE~~ AMOUNTS SHOWN ARE ~~Cigna's~~YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED~~; COPAYMENT AMOUNTS ARE THE INSURED PERSON'S RESPONSIBILITY~~	
Prescription Drugs Benefits **[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.]** **[In the event that ~~y~~You or ~~y~~Your Physician ~~insists on: (a)~~requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between~~amount by which~~ the cost of the "brand-name" drug ~~exceeds~~and the cost of the "generic" drug, plus ~~the~~any required Copayment or Coinsurance ~~identified~~indicated in the Benefit Schedule]** **[Covered in-network only]**		
[[Brand Name] Prescription Drug Deductible [does not apply to [Generic]Drugs]] [(Combined In and Out of Network)]	[$[100-5,000] [per Insured Person,] [per Calendar Year][Integrated medical and prescription drug Deductible]	
Cigna Retail Pharmacy Drug Program **(Maximum [30-90]-day supply)**	YOU PAY PER PRESCRIPTION OR REFILL:~~IN-NETWORK (Based on CIGNACigna contract allowance)~~	YOU PAY PER PRESCRIPTION OR REFILL:~~OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)~~
Preventive Drugs ~~[Generic and Brand with no Generic Alternative]Preventive~~ Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] [Brand Name] with no [Generic]alternative) [Other Preventive Drugs on the Cigna preventive drug list]	~~10~~0% Deductible waived per Prescription or refill [~~10~~0% [Deductible waived] per prescription or refill] [$[5-50]Copayment per prescription or refill]	[[0-~~7~~50]% per Prescription or refill] [Not covered] [[0-~~7~~50]%][Deductible waived] prescription or refill][Not Covered]
Generic drugs ~~*on the Prescription Drug List*~~ (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List]	[$[0-~~1~~200] Copayment per prescription or refill]~~[Cigna Pays[0-100]% [and You pay u~~[Up to a maximum of $[10-100] per prescription or refill]]	[[0-~~7~~50]% per Prescription or refill][$[0-200] Copayment per prescription or refill][Not Covered]

[BENEFIT INFORMATION Note: ~~Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.~~	IN-NETWORK-YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK-YOU PAY (Based on Maximum Reimbursable Charge)
	~~COINSURANCE~~ AMOUNTS SHOWN ARE ~~Cigna's~~YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED~~; COPAYMENT AMOUNTS ARE THE INSURED PERSON'S RESPONSIBILITY~~	
[Generic drugs- on the Prescription Drug List]		
[Brand Name drugs designated as preferred (except as noted under Preventive Drugs)[on the Prescription Drug List][with no Generic equivalent~~, except as noted under Preventive Drugs~~]	[$[10-200] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] ~~[Cigna Pays [0-100]% [and You pay u~~[Up to a maximum of $[20-250] per prescription or refill]] [Not Covered]	[[0-~~7~~50]% per Prescription or refill][$[10-400] Copayment per prescription or refill][Not Covered]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred[on the Prescription Drug List]]	[$[20-300] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] ~~[Cigna Pays [0-100]% [and You pay u~~[Up to a maximum of $[40-500] per prescription or refill]] [Not Covered]	[[0-~~7~~50]% per Prescription or refill][$[20-600] Copayment per prescription or refill][Not Covered]
[**Self-administered injectables][and Specialty Medications]**	[$[50-400] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] ~~[Cigna Pays[0-100]% [and You pay u~~[Up to a maximum of $[50-1,000] per prescription or refill]] [covered under Mail order pharmacy only][Not Covered]	[[0-~~7~~50]% per Prescription or refill] [$[50-800] Copayment per prescription or refill] [Not Covered] [covered under Mail order pharmacy only][Not Covered]
Cigna Tel-Drug Mail Order Pharmacy Drug Program **(Maximum [90-100]-day supply)** **Preventive Drugs**		

[BENEFIT INFORMATION Note: ~~Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.~~	IN-NETWORK-YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK-YOU PAY (Based on Maximum Reimbursable Charge)
	~~COINSURANCE~~ AMOUNTS SHOWN ARE ~~Cigna's~~YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED~~; COPAYMENT AMOUNTS ARE THE INSURED PERSON'S RESPONSIBILITY~~	
~~[Generic and Brand with no Generic Alternative]Preventive~~ Drugs designated by the Patient Protection and Affordable Care Act of 2010~~]~~ as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] [Brand Name] with no [Generic]alternative)	~~10~~0% Deductible waived per Prescription or refill	[Not Available]
[Other Preventive Drugs on the Cigna preventive drug list]	[~~10~~0% [Deductible waived] per prescription or refill] [$[15-125]Copayment per prescription or refill]	[Not Available]
Generic drugs ~~on the Prescription Drug List~~ (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List] **[Generic drugs**- on the Prescription Drug List]	[$[0-200] Copayment per prescription/refill] ~~[Cigna Pays [0-100]% [and You pay u~~[Up to a maximum of $[10-100] per prescription or refill]]	[Not available]
[Brand Name drugs designated as preferred (except as noted under Preventive Drugs) [on the Prescription Drug List][with no Generic equivalent ~~(except as noted under Preventive Drugs)~~]]	[$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] ~~[Cigna Pays [0-100]% [and You pay u~~[Up to a maximum of $[20-250] per prescription or refill]][Not Covered]	[Not available]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred [on the Prescription Drug List]]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [~~[Cigna Pays][0-100]% [and You pay u~~[Up to a maximum of $[40-500] per prescription or refill]][Not Covered]	[Not available]

[BENEFIT INFORMATION Note: ~~Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.~~	IN-NETWORK-YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK-YOU PAY (Based on Maximum Reimbursable Charge)
	~~COINSURANCE~~ AMOUNTS SHOWN ARE ~~Cigna's~~YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED~~; COPAYMENT AMOUNTS ARE THE INSURED PERSON'S RESPONSIBILITY~~	
[**Self-administered injectables][and Specialty Medications]]**	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] ~~[Cigna Pays [0-100]%[and You pay u~~[Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]	[Not available]]

NEW VARIABLE BENEFIT SCHEDULE FOR 5-TIER PHARMACY- OAP/HSP Version

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.] **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
[Prescription Drug Deductible [does not apply to [Tier [1][2]]Drugs]] [(Combined In and Out of Network)]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum [30-90]-day supply)** **[(Maximum [31-100]-day supply) for Maintenance Medications]**	
Tier 1: Retail Preferred Generic	[$[2-10] Copay per Prescription or refill] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 2: Retail Non-Preferred Generic	[$[10-15] Copay per Prescription or refill] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 3: Retail Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 4: Retail Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[[50]% per Prescription or refill][Not Covered]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy (see Mail Order Pharmacy benefits)]]**	[[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You pay 100% of Cigna's discounted cost	[[50]% per Prescription or refill][Not Covered]

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	

of the drug]]

Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	[[50]% per Prescription or refill][Not Covered]
Cigna Tel-Drug Mail Order Pharmacy Drug Program **(**	**Maximum [90-100]-day supply)** **[Maximum [30-100]-day supply for Specialty Medications]**	
Tier 1: Mail Order Preferred Generic	[$[2-10] Copay per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 2: Mail Order Non-Preferred Generic	[$[10-15] Copay per Prescription or refill]] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 3: Mail Order Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[Not available]
Tier 4: Mail Order Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[Not available]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy](see Mail Order Pharmacy benefits)]**	[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill] [and [0-50]% per Maintenance Drug Prescription or refill]	[Not available]

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	[Not available]]

[BENEFIT SCHEDULE [EPO/OAP-INN VERSION]

Following is the Plan Benefit Schedule. The Evidence of Coveraage sets forth, in more detail, the rights and obligations of both You and your your Family Member(s), and the Plan. It is, therefore, important that all Insured Persons **READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY!**

Remember, services from Out-of-Network providers are not covered except for initial care to treat and stabilize an emergency medical condition. For additional details see "

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Medical Benefits	
[Annual]Plan Deductible[*] Individual Family [Please Note: Additional Deductibles may apply to specific benefits.]	**In-Network Deductible** $[0-25,000] $[0-50,000]
[Additional Deductibles] [Some services may require a deductible for that service, and be subject to the [Annual Plan Deductible. Refer to the following pages of this Benefit Schedule for benefits on specific services.]	[Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Co-insurance [The coinsurance level for specialty Physician inpatient/outpatient physician services will differ between CCN and Non-CCN designated specialist services. The term CignaCare Network (CCN) refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.] [Primary Care Provider (PCP)] [CCN-designated PCP] [Specialist] [CCN-designated specialist] [Other Covered Services]	[0-40]% [[0-50]% of Charges[after the Policy Deductible.] [[0-50]% of Charges [after the Policy Deductible].] [[0-50%]of Charges [after the Policy Deductible].] [[0-50%]of Charges [after the Policy Deductible].] [[0-50%]of Charges [after the Policy Deductible].]
Out-of-Pocket Maximum Individual Family [The following do not accumulate to the Out of Pocket Maximum: [Penalties] and Policy Maximums.]	**In-Network Out-of-Pocket Maximum** [$[0-30,000][$0][Not Applicable] [$[0-60,000][$0][Not Applicable]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services [above]for more detailed information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for inpatient admissions; **or Your provider may be assessed a penalty** for non-compliance. **Your Provider must obtain approval** for selected outpatient procedures and services; **or Your provider may be assessed a penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details **[Note**: Voluntary sterilization for men is covered at the regular plan benefit level.]	0% Deductible waived
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than [19]years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits **Comprehensive Eye Exam and Refraction for Children** Limited to one exam per year **Eyeglasses and Lenses for Children** Single Vision, Lined Bifocal, Lined Trifocal, and Lenticular. [Limited to one pair per year] **Theraputic Contact Lenses for Children** Limited to one pair per year] **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	[0-50%% per exam] Deductible waived [0-50% per pair] Deductible waived [0-50% per pair] Deductible waived
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years**	[[0-50]%]~~[[50-100]%]~~

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Note: Services necessary to select, fit and adjust the hearing aid are included in the benefit.	
Physician Services [Primary Care Physician (PCP) services] [Services of a specialist[, with PCP Referral and/or Plan Authorization]	 [(No Referral Required)] [(PCP Referral or Plan Authorization is [NOT]required)]
Office Visit **[(including [allergy testing and treatment/injections][and][lab and x-ray tests][and surgery]done in the office)]** [Primary Care][Physician] [(PCP)] [Non-Cigna Care Designation (CCN) PCP]	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
[Primary Care Physician (PCP) with CCN designation]	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Specialist, (including consultant, referral and second opinion services)[, **with PCP Referral and/or Plan Authorization]** **[Specialist**, (including consultant, referral and second opinion services) **with CCN designation** [, **with PCP Referral and/or Plan Authorization]]** **[Note**: if a Copayment applies for OB/GYN visits:. If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed [with a Cigna Care Designation, You or Your Family Member will pay the CCN specialist copay. If your doctor is listed]as a [non-CCN]]specialist, You or Your Family Member will pay the [non-CCN]specialist Copayment.]	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [[$[10-250] Copayment] [per office visit] [[0-50]%] [with Deductible waived]] [per office visit;] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
Physician Services, continued **[Surgery in Physician's office]** **Outpatient Professional Fees[for Surgery]**[(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy **Inpatient Surgery, Anesthesia, [Radiation Therapy][, Chemotherapy]** **In-hospital visits** **[Allergy testing and treatment/injections]**	[[[0-40]%] [included in Office Visit copayment]] [Deductible waived] [[[0-40]%] [included in outpatient facility copayment]] [Deductible waived] [0-40]% [Deductible waived] [0-40]% [Deductible waived] [[0-40]%[[included in Office Visit copayment]] [Deductible waived]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Hospital Services **Inpatient Hospital Services** [Facility Charges] [Professional Charges] **Emergency Admissions** [Facility Charges] [Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment] [$[500-5,000] Additional Deductible per admission, then][0-50%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment]
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[0-50]%]. [$[500-2,000] Copayment per [service][visit][admission]].
Emergency Services [Emergency services from an Out-of-Network Provider are covered at the In-Network benefit level] **Emergency Room** **Ambulance** [emergency transportation [to the nearest facility][capable of handling the emergency][only.]]	[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]][[0-50]%]] [0-40]%[for [Ground][or]Air][transport]
Urgent Care	[$[25-250] Copayment per visit] [then] [[0-50]%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[0-50]% [MRI:] [MRA:] [PET:] [CT Scan:] [Nuclear Medicine:] [$[100-1,000] Copayment per scan]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
All Other Laboratory and Radiology Services Facility and interpretation charges Physician's Office Free-standing lab or x-ray facility Outpatient hospital lab or x-ray	[$[10-250] Copayment] [[0-50]%][Subject to PCP/specialist office visitbenefit] [0% up to a maximumplan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived] [[0-50]%] [Deductible waived] 0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office Outpatient X-Ray/Lab Facilities] [then] [00-50]%][After Deductible][Deductible waived] [[0-50]%] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]
Short-Term Rehabilitative Services [Physical,] [Occupational,] [Speech,][and Chiropractic] [Therapy] [Acupuncture][/ Acupressure] [Maximum of [10-40] visits per Insured Person, per calendar year,per therapy **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per [day] [visit].]
Cardiac & Pulmonary Rehabilitation [Maximum of [25-60] visits] per Insured Person, per calendar year,per therapy] [Limits based on Medical Necessity guidelines]	[0-50]% [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except$[10-50] per [day] [visit].]
[[Acupuncture][/Acupressure] [Maximum of [10-40] visits per Insured Person, per calendar year for all therapies combined.]	[$[10-250]Copayment] [PCP][or][specialist]office visit benefit applies][per visit][day]] [[0-5]%] [All except [$10-$50] Per Insured Person, per visit.]
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[[0-50]%] Copay or Coinsurance applies for specific benefit provided
Habilitative Services Including **[Physical,] [Occupational,] [Speech] [Therapy]** [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per [day] [visit].]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Womens' Contraceptive Services, Family Planning and Sterilization	[$0] [No charge, no Deductible]
Male Sterilization	Copay or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery) /Complications of Pregnancy	[0-50]%
Initial Office Visit to confirm pregnancy [and subsequent prenatal visits billed separately from the "global" fee]	[$[10-200] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-50]%
Hospital Delivery charges	[[$500-5000] Additional Deductible per admission, then][0-50]%
Prenatal testing or treatment billed separately from "global" fee	[0-50]% [Deductible waived]
Postnatal visit or treatment billed separately from "global" fee	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]

Dental Care (other than Pediatric)	
Limited to treatment for accidental injury to natural teeth within six months of the accidental injury	[0-50]%
Anesthesia for dental procedures for a child under age 8	
Treatment of Diabetes	
(Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Medical Services for Treatment of Phenylketonuria (PKU)	[0-50]%
Autism Spectrum Disorders [For Insured Persons [under age [2110 25 only]] 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) [Maximum of $[36,000-65,000] per year for Applied Behavioral Analysis treatment/therapy per Insured Person]	[PCP or Specialist Office Visit benefit applies][$[10-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [0-50]% Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities [Including]Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities] [Maximum of [20-100] days per Insured Person per calendar year for all facilities listed]	$[500-5000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]
Home Health Services [Maximum [20- 100] [days] [visits] maximum per Insured Person, per calendar year.] [Maximum [4-16]hours per day] [Maximum [2-8] visits per day]	[0-50]%
Durable Medical Equipment	[0-50]%
Prosthetics	[0-50]%
Hospice Inpatient Outpatient	[[0-50]%][Inpatient Hospital Services benefit applies] [[0-50]%] [$[25-250]Copayment per [day][visit]] [Deductible waived]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Dialysis Inpatient Outpatient	Inpatient Hospital Services benefit applies [$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]
[Mental, Emotional or Functional Nervous Disorders Inpatient Outpatient	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-50]%] [$[10-250]]copay][specialist Office Visit benefit applies] [per visit] [[0-50]%] [Deductible waived]
[Substance Abuse Inpatient Rehabilitation [Inpatient Detoxification [only]] Outpatient	[[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [[$[500-5000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [$[10-250] copay][specialist Office Visit benefit applies][per visit]] [[0-50]%][Deductible waived]]
[Smoking Cessation] [	[0-50]%[Deductible waived]]
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility**	[$[500-5000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
[Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility)**]** [Travel benefit Lifetime maximum payment of $[300,000-800,000]] **Other Cigna Network Facility]**	$[10,000-20,000][0%-50]% [$[500-5000] Additional Deductible per admission, then][0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]]
[Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-50]%
[Routine Adult Eye Exam] [Limited to one routine eye exam [per Year][every 2 years]] [Limited to one pair of glasses or contact lenses [per Year][every [2-3] years]]	[Not Covered] [$[10-250 Copayment per exam] [0% up to a maximum of $[15-100] per exam] [0% up to a maximum of $[50-300] for frames, lenses and/or contact lenses]]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
Prescription Drugs Benefits **[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.]** **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
Days Supply	**(Maximum [30-90]-day supply)**	**Maximum [90-100]-day supply) [Maximum [30-100]-day supply for Specialty Medications]**
[[Brand Name] Prescription Drug Deductible [does not apply to [Generic] Drugs]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Preventive Drugs Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative) [Other Preventive Drugs on the Cigna preventive drug list]	0% Deductible waived per Prescription or refill [0% [Deductible waived] per prescription or refill] [$[5-50]Copayment per prescription or refill]	0% Deductible waived per Prescription or refill [0% [Deductible waived] per prescription or refill] [$[15-125]Copayment per prescription or refill]
Generic drugs (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List] **[Generic drugs**- on the Prescription Drug List]	[$[0-200] Copayment per prescription/refill] [Up to a maximum of $[10-100] per prescription or refill]]	[$[0-200] Copayment per prescription/refill] [Up to a maximum of $[10-100] per prescription or refill]]
[Brand Name drugs designated as preferred (except as noted under Preventive Drugs) [on the Prescription Drug List][with no Generic equivalent]]	[$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]]	[$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	[Not Covered]	[Not Covered]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred[on the Prescription Drug List]]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [[Up to a maximum of $[40-500] per prescription or refill]] [Not Covered]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [[Up to a maximum of $[40-500] per prescription or refill]] [Not Covered]
[Self-administered injectables][and Specialty Medications] [on the Prescription Drug List]	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]]
[Prescription Drug Coverage Notes:] • [Coverage includes pain management for terminally ill patients as stated in the Evidence of Coverage]]		

NEW VARIABLE BENEFIT SCHEDULE FOR 5-TIER PHARMACY ---- EPO/OAP-INN etc. PLANS

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
Prescription Drugs Benefits	**(Maximum [30-90]-day supply) [(Maximum [31-100]-day supply) for Maintenance Medications]**	**Maximum [90-100]-day supply) [Maximum [30-100]-day supply for Specialty Medications]**
[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.] **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
[Prescription Drug Deductible [does not apply to [Tier [1][2]]Drugs]] [(Combined In and Out of Network)]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Cigna Pharmacy Retail Pharmacy Drug Program		
Tier 1: Retail Preferred Generic	[$[2-10] Copay per Prescription or refill] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[$[2-10] Copay per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]
Tier 2: Retail Non-Preferred Generic	[$[10-15] Copay per Prescription or refill] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[$[10-15] Copay per Prescription or refill]] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]
Tier 3: Retail Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]
Tier 4: Retail Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy (see Mail Order Pharmacy**	[[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You	[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill] [and [0-50]% per Maintenance Drug Prescription or refill]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
benefits)]]	pay 100% of Cigna's discounted cost of the drug]]	
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	0% Deductible waived per Prescription or refill]

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.

[**Access Fee** refers to the additional amount of Covered Expense which each Insured Person must pay for an emergency room visit that does not result in an admission to the Hospital. Any Access Fees owed are reflected in the Schedule of Benefits section of this Policy.]

[Additional Deductible means an additional amounts of Covered Expenses which the Insured Person must pay before any benefits are available for specific services (e.g., [Brand Name] Prescription Drug Pharmacy Deductible).]

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified][USE STATE-SPECIFIC DEFINITION IF YOU HAVE ONE]

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

[**[Brand Name] Prescription Drug Deductible** means the Additional Deductible that each Insured Person must meet each Year before We will begin paying Covered Expenses for [Brand Name] Prescription Drugs. This Additional Deductible is separate from Deductibles that apply to medical services and does not accumulate toward satisfying the medical Out of Pocket Maximum[s].]

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

[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.]**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

[Copayment/Copay is 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 and Reconstructive 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. 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". For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. [Several types of deductibles may apply to this Policy and all are defined in this section.] [See the definitions for [Additional Deductible,][Individual In-Network Deductible,][, Family In-Network Deductible,][Individual Out-of-Network Deductible,][Family Out-of-Network Deductible][,] [[Brand Name] Prescription Drug Deductible].

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

Diabetes Equipment is blood glucose monitors, including monitors designed to be used by blind persons; insulin pumps and associated appurtenances; to include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies. Podiatric appliances for the prevention of complications associated with diabetes. The repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during

the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

[**Essential Health Benefits**: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedures is considered Experimental or Investigational 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 its is proposed; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or understudy to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis; or
- or reliable evidence shows that the consensus of the 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 stated means of treatment of diagnosis.

Reliable evidence means only; the published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

[**Family Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Family In-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family In-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. There is no Individual Deductible when two or more Insured Persons are covered under this Policy. The Family In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for both medical and pharmacy services, that You must pay for You and Your Family Member(s) collectively before any benefits are available. Once the Family In-Network Deductible has been met all Insured Persons will begin to receive benefits under the Policy. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Family Out-of-Pocket Maximum:** Once the Family Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year. [Other Deductibles,][Pharmacy charges,][Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges]do not apply to the Family Out of Pocket Maximum and will always be paid by You. The Family Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Family In-Network Out-of-Pocket Maximum:** Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. [Deductibles,][Pharmacy charges,][Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges]do not apply to the Family ~~Out-of~~In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family In-Network Out-of-Pocket Maximum:** applies if You have a family plan and You and one or more of Your Family Member(s) are insured under this Policy. Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out-of-Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum includes the Family In-Network Deductible, and is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family Out-of-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. There is no Individual Deductible if You and one or more of your Family Member(s) are insured under this Policy.. The Family Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for [both] medical [and pharmacy] services, that You must pay for You and

your Family Member(s) collectively before any benefits are available. Once the Family Out-of-Network Deductible has been met all Insured Persons will begin to receive benefits under the Policy. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[The **Family Out-of-Network Out-of-Pocket Maximum:** Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. [Deductibles,][Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and]non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[The **Family Out-of-Network Out-of-Pocket Maximum:** applies if You have a family plan and You and one or more of Your Family Member(s) are insured under this Policy. Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Non-Participating Providers, You and Your Family Member(s) will no longer be responsible to pay Coinsurance [and] [Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out of Pocket Maximum and will always be paid by You.The Family Out-of-Network Out-of-Pocket Maximum includes the Family Out-of-Network Deductible, and is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

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

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

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

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

[**Individual Deductible** is the amount of Covered Expenses incurred for medical services that You must pay each Year before any benefits are available. The amount of the Individual Deductible is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Individual In-Network Deductible** is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual In-Network Deductible** applies if You have an individual plan and You are the only person Insured under this Policy. There is no Family Deductible if You are the only person insured under this Policy. The Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for both medical and pharmacy services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Individual Out-of-Pocket Maximum:** Once the Individual Out-of-Pocket Maximum has been met for the Year, for Covered Services, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year. [Deductibles,] [Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges] do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Coinsurance for Covered medical Services. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Individual In-Network Out-of-Pocket Maximum:** Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. [Deductibles,] [Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges] do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual In-Network Out-of-Pocket Maximum:** applies if You have an individual plan and You are the only person insured under this Policy. Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out of Pocket Maximum and will always be paid by You. The Individual In-Network Out of Pocket Maximum includes the Individual In-Network Deductible, and is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY)]]

[**Individual Out-of-Network Deductible** is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. **[**(OAP POLICY LANGUAGE)]

[**Individual Out-of-Network Deductible** applies if You have an individual plan and You are the only person Insured under this Policy. There is no Family Deductible if You are the only person insured under this Policy. The Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for both medical and pharmacy services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Individual Out-of-Network Out of Pocket Maximum:** Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. [Deductibles,][Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and]non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual Out-of-Network Out-of-Pocket Maximum:** applies if You have an individual plan and You are the only person insured under this Policy. Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of-Pocket Maximum includes the Individual Out-of-Network Deductible, and is an accumulation of Covered Expenses incurred from Non-Participating Providers.. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification[and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication].

Injury means an accidental bodily injury.

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

Insured/Policyholder means the ~~person whose application has~~has applicant who has applied for, been accepted ~~by Us~~ for coverage, ~~under this Policy~~and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- [The provider's normal charge for a similar service or supply; or]
- [A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna[; or].]
- [A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.]

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

Medicare The term Medicare means the program of medical care benefits provided under Title XVIII of the Social

Security Act of 1965 as amended.

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. [Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.][REMOVE FOR EPO/OAP- INN PLANS]

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

[**Out-of-Network Out of Pocket Maximum** is the maximum amount of [Deductible,][Copayment][and]Coinsurance each Individual or Family incurs in Covered Expenses from Non-Participating Providers in a Year.] [REMOVE FOR EPO/OAP-INN PLANS]

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons[;][or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons].

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

Pediatric Vision Services means vision care examinations, and other services or treatment described in the "Pediatric Vision Services" section of this Policy provided to an Insured Person who is under age [19-20].

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

Pharmacy is a retail Pharmacy [,][or a mail-order Pharmacy.].

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

[Policy Year is [each 12-month period while this Policy is in effect that begins on the day Your coverage first became effective, if Your coverage was effective on the first day of a month, otherwise the first day of the month following the day Your coverage first became effective][defined as a 12-month period that begins on [12/31/2013][date].
Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.]

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

~~**[Pre-existing Condition** is the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment within a [6-24] month period preceding the Effective Date of coverage under this Policy of an Insured Person age 19 and older, or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a [6-24] month period preceding the Effective Date of the coverage under this Policy of an Insured Person age 19 or older. Genetic information cannot be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.]~~

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

[Preventive Drugs on the Cigna Preventive Drug List are drugs or medications when taken by an Insured Person who has developed risk factors for a disease or condition listed below prior to onset of the disease or condition, or to prevent the reoccurrence of the disease or condition from which an Insured Person has fully recovered:

- [hypertension]
- [high cholesterol]
- [diabetes]
- [asthma]
- [osteoporosis]
- [stroke]
- [prenatal nutrient deficiency]

For example, the treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute Cigna-designated preventive care.]

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

[**Priority Review** is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.]

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

[**Service Area** is any place that is [within the state of [Tennessee.]][within the counties and/or zip code areas in the state of [Tennessee] that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].]

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

[**Special Limits** are limits applied to certain Covered Expenses in the form of [an] [a] [Annual,] [Lifetime,] [per visit,] [per day,] [or] [per event] maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy

will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled "How The Policy Works"]

[**Specialty Medication** means ~~high cost~~ medications which are used to treat an underlying disease which is considered to be rare and chronic, including ~~conditions which include,~~ but ~~are~~ not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.]

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

[**Telemedicine Medical Services** is a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile.]

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse[or partner to a civil union].
- Your children who have not yet reached age [26-30].
- Your stepchildren who have not yet reached age [26-30].
- [Your [unmarried]grandchildren who have not yet reached age [19-30] if they are Your dependents for Federal Income Tax purposes at the time of application.]
- [Your own, [or] Your spouse's [or Your partner to a civil union's] unmarried children, regardless of age, enrolled prior to age [26-30], who are incapable of self support due to [medically certified]continuing [mental or physical]disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's [19-30]th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, [or]Your spouse's [or Your partner to a civil union's] Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna [in writing] within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- [Your Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is Your dependent for Federal Income Tax purposes at the time of application. To continue coverage, You must notify Cigna within 31 days of the Newborn grandchild's date of birth that You wish to have the Newborn grandchild added as an Insured Family Member, and pay any additional premium required.]
- [An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of [the adopted child's placement for]adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of [placement for]adoption or initiation of a suit of adoption, and paying any additional premium.]
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents[, and We must receive that application] during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next

Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on a state exchange ("on exchange" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move[(including a move outside the service area of the individual's current plan)]; or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on a state exchange ("off-exchange plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or

- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move[(including a move outside the service area of the individual's current plan)]; or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- [The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or
- The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for misrepresentations or intentionally omitted information or health history[; or
- The individual is eligible for Medicare Part A and Part B, or Part B only, or Part D, or is eligible for any Medicare benefit Policy offered by Cigna, any direct or indirect affiliate of Cigna.]

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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;~~.~~
- [When the Insured no longer lives in the Service Area.]

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability[.]~~[, and no pre-existing condition limitation will be imposed[, unless unexpired prior to continuation under this Policy.]~~

How The Policy Works

This section describes [Deductibles][Access Fees] and [Copayments][/][Coinsurance] and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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 in the case of initial treatment and Stabilization of a Medical Emergency, as indicated below under "Special Circumstances".][USE FOR EOP/OAP-INN PLANS ONLY]

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

[Non-Participating Hospitals, Non-Participating Physicians, and Other Non-Participating Providers.

Covered Expenses for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, or a Maximum Reimbursable Charge. These services may be subject to additional penalties and/or Deductibles.][REMOVE FOR EPO/OAP-IN PLANS]

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

~~[We will NOT apply [Deductibles,][Copayments][or][Coinsurance]paid to Non-Participating Providers toward the Out of Pocket Maximum for Participating Providers.]~~

- **[Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.]

  ~~[We will NOT apply [Deductibles,][Copayments][or][Coinsurance]paid to Non-Participating Providers toward the Out of Pocket Maximum for Participating Providers.]~~

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. [All Additional Deductibles apply to only certain provider or service types.]Deductibles do not include any amounts in excess of Maximum Reimbursable Charges,[Coinsurance,][Prescription Drug Copays,][Access Fees][Copayments] any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

[If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.]

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- [If You cover other Family Member(s), 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 Family Deductible is required for the remainder of that Year.[(EPO/OAP-INN POLICY LANGUAGE)]]

- [If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.[(OAP POLICY LANGUAGE)]]
- [If You cover other Family Member(s), the Family In-Network Deductible will apply. Covered Expenses for You and your Family Member(s) will collectively accumulate until the Family In-Network Deductible has been satisfied. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

- [If the In-Network Deductible is not met in a given Year, Covered Expenses incurred from October through December and applied toward the In-Network Deductible for that Year will also be applied toward the In-Network Deductible for the next Year. If the In-Network Deductible is satisfied in a given Year, We will not carryover any amount applied toward that In-Network Deductible to the next Year's In-Network Deductible.]

[Out-of-Network Deductible[(remove this section from EPO/OAP-INN plans)]

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. [If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible.] Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.

- [If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year. [(OAP POLICY LANGUAGE)]]

- [If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Covered Expenses for You and your Family Member(s) will collectively accumulate until the Family Out-of-Network Deductible has been satisfied. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[Additional Deductibles[and [Access Fees][Copayments]]

This benefit Policy may contain Additional Deductibles [and/or Access Fees]which are specific to certain benefits. Please see the Benefit Schedule for specific dollar amounts.

- [Emergency room services: An [**Additional**][**Access Fee][Copayment]** per visit will apply[, unless the visit results in an inpatient admission into that Hospital immediately following the Emergency room visit].]

- [Inpatient Hospital stay: An additional Deductible will apply per admission.]

- [Pharmacy: An **Additional Deductible** per Year will apply for [Brand Name][Tier[s] [2][3][4][5]] Prescription Drugs. Each Insured Person must meet the Prescription Drug Deductible each Year before receiving benefits for [Brand Name] Tier[s] [2][3][4][5]] Formulary and Non-Formulary Prescription Drugs. This Deductible is separate from other benefits and does not accumulate toward satisfying any other Deductible. See the section entitled "Prescription Drug Benefits".]]]

Out of Pocket Maximum[s]

The Out of Pocket Maximums are the amount of ~~[~~Coinsurance,~~]~~ ~~]~~[Deductible, ~~]~~[and Copayment ~~]~~each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of [Maximum Reimbursable Charges,]~~[Copayments,][Prescription Drug Copayments,][Access Fees][charges for Infusion and Injectable Specialty Prescription Medications,] [any Deductible amounts,]~~any penalties, ~~[any treatment for Mental or Nervous Disorders]~~or any amounts in excess of other benefit limits of this Policy.

- [Once an Insured Person reaches the Out of Pocket Maximum in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year.][(EPO/OAP-INN POLICY LANGUAGE)]

- [Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.]

- [If you cover other Family Member(s), each Insured Person's Covered Services accumulate toward the Family Out of Pocket Maximum. Once the Out of Pocket has been met, the Family will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year.][(EPO/OAP-INN POLICY LANGUAGE)]

- [If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.]

[Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on [Annual,] [Lifetime][or][payment][Maximums which may apply to]these specific Benefits.

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[s];
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

[If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.]

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- [Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.]
- [Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.]
- [Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.]

The Insured Person must satisfy any applicable penalty before benefits are available.]

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, [Deductibles,][penalties,]exclusions, [Waivers]and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

[To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").]
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

For any eligible condition [that is Authorized by Cigna,]this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

[To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program"). **]**
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

[In addition,]the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- [Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification[and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication].;]and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;

- Not for exercise; and
- And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

[Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.]

~~Autism Spectrum Disorders~~

~~Benefits provided by this Plan are available for Insured Persons less than 12 years of age for treatment of neurological disorders, usually appearing in the first 3 years of life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.~~

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy[, Chiropractic][,and Speech Therapy][and] [Acupuncture/Acupressure])

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

The term ["visit"][“day”]includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, [manipulation of the spine,]or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the [combined maximum payment][and] [maximum number of [visits][days] as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the [combined maximum payment] [and] [number of [visits] [days] as stated in the Benefit Schedule.

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

[Special Note:
Additional [visits][days] for Physical or Occupational Therapy may be covered following severe trauma such as:
- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and

- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.**]**

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

The term ["visit"][“day”]includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Benefits for 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 are payable up to the [combined maximum payment][and][maximum number of [visits][days] as stated in the Benefit Schedule.

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

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

[Special Note:
Additional [visits][days] for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional [visits][days] in advance of treatment being provided.

[Acupuncture[/Acupressure] Services

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

The term ["visit"][“day”]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][day] and will not be reimbursed in addition to the [visit][day].]

[Special Note:
Additional [visits][days] for Acupuncture treatment may be covered following severe trauma such as:

- an inpatient hospitalization due to severe injury or trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and

Cigna authorizes this in advance.]]

[Services for Mental, Emotional or Functional Nervous Disorders [and Substance Abuse]

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

In order to qualify for benefits, services for [Mental, Emotional or Functional Nervous Disorders,][,or][substance abuse]must meet the following conditions:

- Services must be for the treatment of [a Mental, Emotional or Functional Nervous Disorder,][,or][substance abuse]and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition~~, and for a number of days or visits which do not exceed the maximums as stated in the Benefit Schedule~~.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.**]**

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition~~ for an Insured or an Insured's spouse~~. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. ~~No b~~Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".~~including but not limited to normal deliveries, elective cesarean sections and non-elective cesarean sections when a viable birth is possible, and elective abortions. Elective abortions will not include those performed when the life of the mother is threatened or when the fetus is not viable.~~

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

[All Preventive Care Services [(birth and older)]

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

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

- Routine physical exams.
- Annual mammogram, Pap test and PSA.
- [United States Preventive Services Task Force (USPSTF) for services rated "A" or "B",] [Advisory Committee on Immunization Practices (HRSA)] recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect an rating of "A" or "B" rating in the current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html]]

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.]

Genetic Testing

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

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.

[Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent of an Insured Person has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.][**use ONLY if plan covers infertility]**

[Genetic counseling is covered if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.]

Hearing Aids

Hearding aids for children to age 18 are covered as specified in the Benefit Schedule.

[Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses for Insured Persons [under age][10-25]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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

   Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. [COVER ONLY IF MANDATED, THIS LANGUAGE IS A PLACE-HOLDER]
3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
   a) self care and feeding,
   b) pragmatic, receptive, and expressive language,
   c) cognitive functioning,
   d) applied behavior analysis, intervention, and modification,
   e) motor planning, and
   f) sensory processing.

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

Organ and Tissue Transplants

[To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").]
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the~~is~~ Policy for:

- An Insured Person who receives the organ or tissue.

- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant
- ~~peripheral stem cell transplant and similar procedures~~

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

[All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.] [(Remove for EPOPLANS/ USE FOR OAP-INN PLANS)]

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. [Transplant services received at any other facilities, including Non-Participating Providers [and Participating Providers contracted with Cigna for other services, but not for transplant services,]are [not covered] [covered at the Out-of-Network benefit level].] [(remove from '[Transplant services received at any other…. to end for EPO/OAP-INN PLANS)]][BLUE HIGHLIGHT USE FOR OAP-INN PER LANGUAGE FROM STATE FILINGS]

[The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- [The donor, if the recipient is an Insured Person.]

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion [and a donor]will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.]

[Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement [of $[10,000-80,000] per lifetime,]as shown in the Plan Benefit Schedule.]

[Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $[100-500]per day.]

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

[**The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:**

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.]

<u>Treatment of Diabetes</u>

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

Treatment Received from 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 does not accept assignment of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, [Waivers,]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.

[Telehealth/Telemedicine Medical Services

Services for Telehealth/Telemedicine are covered under this Policy on the same basis as any other medical benefit. Please refer the the “Definitions” section of this Policy for a complete description of the services.]

Home Health Care

[To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled “Prior Authorization Program”).]
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. [**Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. [Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of [6-8] visits per day, and prescribed by a Physician[in lieu of hospitalization].] Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.

- Services of a medical social worker.

[Private duty nursing services are not covered, even if provided as part of a home health care treatment program.]

[Smoking Cessation

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

This Policy provides benefits for Covered Expenses for any smoking cessation program designed to end the dependency on nicotine, [up to the maximum payment][as]shown in the Benefit Schedule.]

[Injury While Intoxicated or Under the Influence of a Narcotic]

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.]

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for TMJ (Temporomandibular Joint Dysfunction) (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- ~~[Conditions which are **pre-existing** as defined in the Definitions section.] *Remove this text for Guarantee Issue HIPAA Policys*~~

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- [Any ~~coverage provided or available~~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, ~~plan~~** even if the Insured Person does not claim those benefits.]
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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].
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- [If the Insured Person is eligible for Medicare ~~p~~Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.]
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- [[Inpatient][or][outpatient][services of a private duty nurse[, except as specifically stated under Home Health Care in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For"].]

- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- 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.
- 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.
- ~~[Treatment of **Mental, Emotional or Functional Nervous Disorders** or psychological testing except as specifically provided in this Policy. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.]~~
- [Smoking cessation programs[, except as specifically provided in this Policy].]
- ~~Treatment of substance abuse [,except as specifically provided in this Policy].~~
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** for Insured Person's 19 and over, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems. [For the purposes of this exclusion, a hearing aid is any device that amplifies sound.]
- Routine **hearing tests** except as specifically provided ~~in this Policy~~ under ~~"Comprehensive Benefits, What the Plan Pays For".~~ Preventive Care and Newborn Hearing Benefits.
- [Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.]
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy** [, expect as specifically stated in this Policy].]
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of [varicose veins;]abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- [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].]
- [Non-Medical counseling or ancillary services, including but not limited to: [education,][training,][vocational rehabilitation,][behavioral training,][biofeedback,][neurofeedback,][hypnosis,][sleep therapy,][employment counseling, back school, return to work services, work hardening programs, driving safety,] [and services,][training,][educational therapy][or][other nonmedical ancillary services for learning disabilities and developmental delays].]

- [Services for redundant skin surgery, removal of skin tags, [acupressure,][acupuncture,]carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.]
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy[except if this is a result of an [Accidental Injury,][organic cause,][trauma,][infection,][or][congenital disease or anomalies]].
- [All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT)[, except as specifically stated in this Plan].]
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- [All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.]
- [Injectable drugs ("self-injectable medications) that do not require Physician supervision are covered under the Prescription Drug benefits of this Policy.]
- [All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.]
- [Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy~~[except as stated in the Prescription Drug Benefit Schedule and/or the Prescription Drug Benefits section of this Policy]~~[, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription]. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.]
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), ~~or~~ shoe inserts, ~~including~~foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, ~~including~~ physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.

- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters[, unless provided via an approved internet-based intermediary].
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **[Massage Therapy.]**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- ~~**Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.~~
- ~~**Syringes**, except as stated in the Policy.~~
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **[[Growth Hormone Treatment[.]][**except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition.] [Growth hormone treatment]for [idiopathic short stature,][or] improved athletic performance is not covered under any circumstances.]]
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet[except as otherwise stated in this Policy].
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- ~~Charges for **Normal Pregnancy or Maternity Care**, including normal delivery, elective abortions or [elective/non-emergency]cesarean sections except as specifically stated under 'Complications of Pregnancy' in the 'Comprehensive Benefits' section of this Policy.~~
- Claims received by Cigna after [10-15] months from the date service was rendered, except in the event of a legal incapacity.
- ~~Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority, including physical exams required for or by an employer, or for school, or sports physicals, except as otherwise stated in this Plan.~~

[Pre-existing Condition Periods

Any services received by an Insured Person age 19 and over, on or within 12 months after the Effective Date of coverage will not be covered, if they are related to a Pre-existing Condition, as defined in the Definitions section of this Policy, which existed within a 12 month period preceding the Effective Date of coverage.

[Creditable Coverage for Pre-existing Conditions

The exclusion for Pre-existing Conditions does not apply to an Insured Person under age 19, or to an Insured Person age 19 or older who was continuously covered for an aggregate period of 18 months by Creditable Coverage, that was in effect up to a date not more than 63 days prior to the Effective Date of the Insured Person's coverage under this Policy, excluding any waiting period.] [Proof of Creditable coverage is required.]

[Creditable Coverage is coverage under any of the following:

1. [a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.);]
2. [any group [or individual]health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;]
3. [Chapter 55 of Title 10, United States Code;]
4. [a medical care program of the Indian Health Service or of a tribal organization;]
5. [a state health benefits risk pool;]
6. [a health Policy offered under Chapter 89 of Title 5, United States Code;]
7. [a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country;]
8. [a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.]

[Waiting Periods

An Insured Person must be insured for [3-6]consecutive months under this Policy to be eligible for benefits for all services, including but not limited to, all tests, consultations, examinations, medications; and invasive, medical, laboratory or surgical procedures that are related to the evaluation or treatment of:

1. [hernia except for strangulated or incarcerated hernia.]
2. [any disorder of the reproductive organs.]
3. [varicose veins.]
4. [hemorrhoids.]
5. [any disorder of the tonsils or adenoids,]
6. [gall bladder,]
7. [appendix.]

However, the [3-6]month waiting period will not apply if the treatment is for a Medical Emergency.

If You are admitted to a Hospital or Skilled Nursing Facility for any of the conditions requiring fulfillment of the Waiting Period before the end of the Waiting Period, no benefits will be provided for any portion of that Hospital or Skilled Nursing Facility stay.]

Prescription Drug Benefits

Pharmacy Payments

[Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the ~~any applicable [Deductibles,][~~Copayment~~s~~][~~and~~][~~or~~] [~~Coinsurance~~] shown in the Benefit ~~Summary.~~ Schedule, after You have satisfied any applicable [Brand Name][Prescription Drug][Plan]Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.] [OAP version]

[Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and, once the Deductible is satisfied, subject to any applicable [Copayments][and][or] [Coinsurance] shown in the Benefit Summary.]
[HSP version]

[When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for Your convenience, a Copayment will apply to each Prescription Drug.][**use with copay plans only**]

[When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment [and][or][Coinsurance]will apply to each Prescription Drug.]

[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-name"][“generic”] Copayment. shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.]

[Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.]

[[Brand Name] Prescription Drug Deductible

A [Brand Name]Prescription Drug Deductible must be satisfied by each Insured Person, each calendar year before We will pay for any Prescription Drugs or Related Supplies. This Additional Deductible is separate from Deductibles that apply to medical services ~~and does not accumulate toward satisfying the medical Out of Pocket Maximums~~.]

Covered Expenses

If the Insured Person(s), while covered under this Policy~~insured for Prescription Drug Benefits~~, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. [Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.] When ~~the Insured Person(s) is~~You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- [Generic] Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs[except Insulin pens and cartridges].

- [Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.]
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- [Contraceptive Drugs and devices approved by the FDA.]
- [Maintenance Drugs][and][Specialty Medications are covered.]

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- Approved for use by the Food and Drug Administration (FDA)[; or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  - a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  - b. it has been otherwise approved by the FDA; and
  - c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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.a 30-day supply (unless ordered by mail through the mail order pharmacy program, in which case the limit is a 90-day supply).
- [Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification[and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication.]
- [Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. In the event that you or your Physician insists on: (a) a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, 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 required Copayment or Coinsurance identified in the Benefit Schedule.]

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- [infertility drugs;]

- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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.
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- 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 United States Pharmacopeia Drug Information or~~ The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals~~national professional medical journal~~;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- [Brand-Name drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List;]
- [Drugs that are not on the Prescription Drug List]
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and ~~dietary supplements~~flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- [prescription smoking cessation products;]
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment [except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition;] [growth hormone treatment]for [idiopathic short stature,][or] improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue;
- ~~[brand-name preferred, brand-name non-preferred or self-injectable prescription drugs.];~~
- [pre-filled ~~-~~insulin pens and cartridges]

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive [30-90]-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive [90-100]-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.
- [up to a consecutive [30-100]-day supply for [the first fill]of Specialty Medications] [and][Self-Administered Injectable Drugs],at a Retail [Participating]Pharmacy unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive [30-100]-day supply for [the first fill]of Specialty Medications] [and][Self-Administered Injectable Drugs],at a home delivery [Participating]Pharmacy unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive [90-102] day supply, [excluding][after][the first fill of][Specialty Medications] [and][Self-Administered Injectable Drugs], at a home delivery [Participating]Pharmacy, unless limited by the drug manufacturer's packaging; or]
- [limited to one fill of a Specialty Medication [or a Self-Administered Injectable Drug]at a retail [Participating]Pharmacy. If You exceed the one fill allowed at a retail [Participating]Pharmacy, You will be responsible for 100% of Cigna's discounted cost for the prescription.]
- [Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- [Maintenance Drugs][and Specialty Medications][refills are covered at the retail pharmacy benefit level for the first [1-3]fills; any fills after the first [1-3]]are covered only through the Cigna Mail order pharmacy.]
- [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.]

[Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.]

[Coverage for Specialty Medications [and][Self-Administered Injectable Drugs] provided by a [Participating]retail Pharmacy is limited to the initial fill of each Prescription. After the initial fill at a retail Pharmacy those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List. Any subsequent fill of that Prescription must be made at a home delivery Pharmacy, or You will be responsible for 100% of Cigna's discounted cost for the prescription.]

[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

[In the event that yYou or yYour Physician insists on: (a)requests a more expensive "brand-name" drug that has a generic equivalentwhere a "generic" drug would otherwise have been dispensed, yYou 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-name"]["generic"]required Copayment identifiedshown in the Schedule.]

[All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.]

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. After such sixth month period, all newly approved FDA drugs will be designated as either non-Preferred or non-Prescription Drug List drugs for the first sixth months of coverage until the P& T Committee evaluates the Prescription Drug clinically for a different designation.]

[All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a

different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

[All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such sixth month period, all newly approved FDA drugs will be designated as either non-Preferred or non-Prescription Drug List drugs for the first sixth months of coverage until the P&T Committee evaluates the Prescription Drug clinically for a different designation.]

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.]

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. [Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.] If ~~the~~Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request [a Prescription Drug List exception or]Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, ~~the~~Your Physician will receive confirmation. The Prior Authorization will be processed in ~~o~~Our claim system to allow ~~the Insured Person~~You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When ~~the~~Your Physician advises ~~the Insured Person~~You that coverage for the Prescription Drugs or Related Supplies has been approved, ~~the Insured Person~~You should contact the Pharmacy to fill the prescription(s).

If the request is denied, ~~the~~Your Physician and ~~the Insured Person~~You will be notified that coverage for the Prescription Drugs or Related Supplies was not authorized.

If ~~the Insured Person~~You disagree~~s~~ with a coverage decision, ~~they~~You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If ~~the Insured Person has~~You have questions about specific Prescription Drug List exceptions or]a ~~specific~~ Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

[Pediatric Vision Benefits for Care Performed by an Ophthalmologist or Optometrist

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

Definitions

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

Pediatric Vision Services means routine vision care examinations, preventive treatment and other services or treatment described in the "Pediatric Vision Services" section of this Policy provided to an Insured Person who is under age [0-20].

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable~~:~~

~~1.~~ We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

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.

Other Insurance

The Insured Person may have Other Valid Coverage (with another insurer) which applies to a loss covered by this Policy. Other Valid Coverage may reduce the benefits payable under this Policy. The benefits payable under this Policy will not be reduced by Other Valid Coverage if the Insured Person has notified Us in writing that they do have Other Valid Coverage. The Insured Person must notify Us before a loss begins. The benefits payable under this Policy will be reduced by Other Valid Coverage if the Insured Person has not notified Us in writing (before the loss begins) that the Insured Person does have Other Valid Coverage. The amount of he reduced benefits payable under this Policy will be determined by applying the formula below:

ADD: The benefit which would have been payable under this Policy,

PLUS: The total of the like benefits under all Other Valid Coverage's on the same loss of which We have had notice,

DIVIDED BY: The total like benefits under all valid coverage's for such loss.

When benefits are reduced due to Other Valid Coverage, We will return part of the last premium paid prior to the commencement of a loss covered under this Policy. The proportion We will use to determine the premium refund will be the same proportion We use to determine the benefit reduction in the formula above.

When Other Valid Coverage is written on a provision of service basis, the "like amount" of such other coverage will mean the dollar amount which the services received would have cost if the Insured Person did not have the other coverage.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits , you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within [180 days-365 days] of receipt of the denial notice, to the following address:

[Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422[I1]]

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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours , followed up in writing.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different

determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 - 180 days] of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health

insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

[Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the [Commercial Arbitration Rules of the American Health Lawyers Association], to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. [To the extent permitted by law,]the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.]

Terms of the Policy

Entire Contract; Changes: 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 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: ~~(a)~~ 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. ~~(b) No claim for loss~~

~~incurred after one year from the Effective Date of any Insured Person age 19 or over shall be reduced or denied on the ground that a disease or physical condition was a Pre-existing Condition.~~

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. ~~T~~there is a grace period of [10-31]days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the [10-31]day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. [When the Insured no longer lives in the Service Area.]

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

[Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverage~~'~~s, 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.] [We will send written notice and the change will become effective on the next scheduled monthly or quarterly payment premium due date. This Individual Plan is renewable [Monthly or Quarterly][or][Annually], payment of the premiums will indicate acceptance of the change.]

[Member Services][Additional Programs]: We may, from time to time offer, or arrange for various entities to offer, discounts, benefits, or other consideration to You for the purpose of promoting Your general health and well being.]

Reinstatement: If this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. [However, if We require an application for reinstatement, We will only reinstate this Policy if We approve Your reinstatement application. We will otherwise notify You in writing that We have disapproved Your reinstatement application.][However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.]

If this Policy is reinstated, [benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise,]You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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

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

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if

the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna CLAIM OFFICE.
  - ~~1.~~ YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
  - ~~2.~~ YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM.

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

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

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

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

[Payment of Claims: We may pay all or a portion of any indemnities provided for health care services to the participating health care services provider, unless You direct otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services provider directly to You, unless You direct otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular health care services provider. In the event of Your death, We will issue any benefits payable to You to the beneficiary of Your estate. In the absence of a valid release, We may pay up to $2000 to someone whom We deem entitled.]

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

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

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

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

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

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

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

[You will be responsible for an additional [$][5-50]charge for any check or electronic funds transfer that is returned to Us unpaid.]

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of [10-31]days for the receipt at our office ~~T~~there is a grace period of [10-31]days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 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.

Plans & Benefits Template v1.31

HIOS Issuer ID*	99248
Issuer State*	TN
Market Coverage*	Individual
Dental Only Plan*	No
TIN*	59-1031071

To use this template, please review the user guide and instructions.
You will need to save the latest version of the add-in file (PlansBenefitsAddIn.xlam) on your machine.
To create the cost share variance worksheet and enter the cost sharing amounts for both individual and SHOP (small g
To create additional Benefits Package worksheets, use the Create New Benefits Package macro.
To populate the benefits on the Benefits Package worksheet with your State EHB Standards, use the Refresh EHB mac

Plan Identifiers								
HIOS Plan ID* (Standard Component)**	**Plan Marketing Name***	**HIOS Product ID***	**HPID**	**Network ID***	**Service Area ID***	**Formulary ID***	**New/Existing Plan?***	**Plan Type***
99248TN0020001	myCigna Health Savings 6100	99248TN002	7730182962	TNN001	TNS001	TNF001	New	PPO
99248TN0020003	myCigna Health Savings 3400	99248TN002	7730182962	TNN001	TNS001	TNF001	New	PPO
99248TN0020006	myCigna Health Savings 1900	99248TN002	7730182962	TNN001	TNS001	TNF001	New	PPO

roup) markets, use the Create Cost Share Variances macro.

cro.

					Plan Attributes		
Level of Coverage*	**Unique Plan Design?***	**QHP/Non-QHP***	**Notice Required for Pregnancy***	**Is a Referral Required for Specialist?***	**Specialist(s) Requiring a Referral**	**Plan Level Exclusions**	**Limited Cost Sharing Plan Variation - Est Advanced Payment**
Bronze	Yes	Both	No	No			$0.00
Silver	Yes	Both	No	No			$0.00
Gold	Yes	Both	No	No			$0.00

							Stand Alone Dental Only	
HSA Eligible*	**HSA/HRA Employer Contribution**	**HSA/HRA Employer Contribution Amount**	**Child-Only Offering***	**Child Only Plan ID**	**Wellness Program Offered***	**Disease Management Programs Offered**	**EHB Apportionment for Pediatric Dental**	**Guaranteed vs. Estimated Rate**
Yes			Allows Adult and Child-Only		No	Diabetes		
Yes			Allows Adult and Child-Only		No	Diabetes		
Yes			Allows Adult and Child-Only		No	Diabetes		

AV Calculator Additional Benefit Design				*Plan Dates*		
Maximum Coinsurance for Specialty Drugs	**Maximum Number of Days for Charging an Inpatient Copay?**	**Begin Primary Care Cost-Sharing After a Set Number of Visits?**	**Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?**	**Plan Effective Date***	**Plan Expiration Date**	**Out of Country Coverage***
				01/01/2014		Yes
				01/01/2014		Yes
				01/01/2014		Yes

Geographic Coverage				URLs	
Out of Country Coverage Description	**Out of Service Area Coverage***	**Out of Service Area Coverage Description**	**National Network***	**URL for Summary of Benefits & Coverage**	**URL for Enrollment Payment**
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		

Plan Brochure

Benefit Information			General Information				
Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay
Primary Care Visit to Treat an Injury or Illness	Yes		Covered				
Specialist Visit	Yes		Covered				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered				
Outpatient Surgery Physician/Surgical Services	Yes		Covered				
Hospice Services	Yes		Covered				
Non-Emergency Care When Traveling Outside the U.S.	Yes		Covered				
Routine Dental Services (Adult)							
Infertility Treatment	Yes		Not Covered				
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing							
Routine Eye Exam (Adult)							
Urgent Care Centers or Facilities	Yes		Covered				
Home Health Care Services	Yes		Covered	Yes	60	Visit(s) per Year	
Emergency Room Services	Yes	Yes	Covered				
Emergency Transportation/Ambulance	Yes		Covered				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes		Covered				
Inpatient Physician and Surgical Services	Yes		Covered				
Bariatric Surgery							
Cosmetic Surgery							
Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Year	
Prenatal and Postnatal Care	Yes		Covered				

			Deductible and Out of Pocket Exceptions			
Exclusions	Explanation (text field)	EHB Variance Reason	Subject to Deductible (Tier 1)	Subject to Deductible (Tier 2)	Excluded from In Network MOOP	Excluded from Out of Network MOOP
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Pharmacy benefits, transplants, dialysis,			Yes	Yes	No	No
	Benchmark plan covers Family	Other Law/Regulati	Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No

Delivery and All Inpatient Services for Maternity Care	Yes		Covered		
Mental/Behavioral Health Outpatient Services	Yes		Covered	No	
Mental/Behavioral Health Inpatient Services	Yes		Covered	No	
Substance Abuse Disorder Outpatient Services	Yes		Covered	No	
Substance Abuse Disorder Inpatient Services	Yes		Covered	No	
Generic Drugs	Yes		Covered		
Preferred Brand Drugs	Yes		Covered		
Non-Preferred Brand Drugs	Yes		Covered		
Specialty Drugs	Yes		Covered		
Outpatient Rehabilitation Services	Yes		Covered		
Habilitation Services	Yes	Yes	Covered		
Chiropractic Care	Yes		Covered	Yes	20 Visit(s) per Year
Durable Medical Equipment	Yes		Covered		
Hearing Aids	Yes	Yes	Covered		
Imaging (CT/PET Scans, MRIs)	Yes		Covered		
Preventive Care/Screening/Immunization	Yes	Yes	Covered		
Routine Foot Care	Yes		Covered		
Acupuncture					
Weight Loss Programs					
Routine Eye Exam for Children	Yes		Covered	Yes	1 Visit(s) per Year
Eye Glasses for Children	Yes		Covered	Yes	1 Item(s) per Year
Dental Check-Up for Children	Yes		Not Covered		
Rehabilitative Speech Therapy	Yes		Covered	Yes	20 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered	Yes	40 Visit(s) per Year

			Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Refers to preferred and non-preferred	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Limited to members under the age of 18	1 unit per year every 3 years	Substantially Equal	Yes	Yes	No	No
			Yes	Yes	No	No
	Well Care visit limited to 1 per year except		No	No	No	No
Routine foot care for the treatment of (1) flat	Routine foot care for members with	Substantially Equal	Yes	Yes	No	No
	Plan will pay up to $30 when using an out-of-	Substantially Equal	No	No	No	No
	Benefit may also be 1 pair of contact lenses	Substantially Equal	No	No	No	No
		Dental Only Plan A	No	No	No	No
	Same limits and coverage apply for	Substantially Equal	Yes	Yes	No	No
	Limited to 20 visits per year occupational	Substantially Equal	Yes	Yes	No	No

Well Baby Visits and Care			Covered
Laboratory Outpatient and Professional Services	Yes		Covered
X-rays and Diagnostic Imaging	Yes		Covered
Basic Dental Care – Child	Yes		Not Covered
Orthodontia – Child	Yes		Not Covered
Major Dental Care – Child	Yes		Not Covered
Basic Dental Care – Adult			
Orthodontia – Adult			
Major Dental Care – Adult			
Abortion for Which Public Funding is Prohibited			
Transplant	Yes		Covered
Accidental Dental			Covered
Dialysis			Covered
Allergy Testing			Covered
Chemotherapy			Covered
Radiation			Covered
Diabetes Education			Covered
Prosthetic Devices	Yes		Covered
Infusion Therapy			Covered
Treatment for Temporomandibular Joint Disorders	Yes		Covered
Nutritional Counseling			Covered
Reconstructive Surgery	Yes	Yes	Covered
Clinical Trials		Yes	Covered
Diabetes Care Management		Yes	Covered

	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
	Dental Only Plan Available				
	Dental Only Plan Available				
	Dental Only Plan Available				
Dollar limit only applies to	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
Limited to medically-necessary routine care	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No

Inherited Metabolic Disorder - PKU		Yes	Covered			
Off Label Prescription Drugs		Yes	Covered			
Dental Anesthesia		Yes	Covered			
Congenital Anomaly, including Cleft Lip/Palate		Yes	Covered			
Cardiac and Pulmonary Rehabilitation			Covered	Yes	36	Visit(s) per Year
Family Planning Services	Yes		Covered			

		Yes	Yes	No	No
The cost-sharing for off label prescription	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
36 Visits for Cardiac an	Additional EHB Ber	Yes	Yes	No	No
This benefit is a clarific	Other Law/Regulati	No	No	No	No

Cost Sharing Reduction Information										
HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*	Medical & Drug Maximum Out of Pocket Integrated?*	Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
99248TN0020001-00	myCigna Health Savings (	Bronze	Standard Bronze Off Exchang	58.20%	58.01%	Yes	Yes	No	100%	
99248TN0020001-01		Bronze	Standard Bronze On Exchang	58.20%	58.01%	Yes	Yes	No	100%	
99248TN0020001-02		Bronze	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No	100%	
99248TN0020001-03		Bronze	Limited Cost Sharing Plan Var	58.20%	58.01%	Yes	Yes	No	100%	
99248TN0020003-00	myCigna Health Savings 3	Silver	Standard Silver Off Exchange	68.40%	63.15%	Yes	Yes	No	100%	
99248TN0020003-01		Silver	Standard Silver On Exchange	68.40%	63.15%	Yes	Yes	No	100%	
99248TN0020003-02		Silver	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No	100%	
99248TN0020003-03		Silver	Limited Cost Sharing Plan Var	68.40%	63.15%	Yes	Yes	No	100%	
99248TN0020003-04		Silver	73% AV Level Silver Plan	73.20%	68.44%	Yes	Yes	No	100%	
99248TN0020003-05		Silver	87% AV Level Silver Plan	86.60%	81.30%	Yes	Yes	No	100%	
99248TN0020003-06		Silver	94% AV Level Silver Plan	94.30%	86.12%	Yes	Yes	No	100%	
99248TN0020006-00	myCigna Health Savings :	Gold	Standard Gold Off Exchange F	78.60%	70.65%	Yes	Yes	No	100%	
99248TN0020006-01		Gold	Standard Gold On Exchange F	78.60%	70.65%	Yes	Yes	No	100%	
99248TN0020006-02		Gold	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No	100%	
99248TN0020006-03		Gold	Limited Cost Sharing Plan Var	78.60%	70.65%	Yes	Yes	No	100%	

SBC Scenario								*Maximum Out of Pocket for Medical EHB Benefits*							
Having a Baby				**Having Diabetes**				**In Network**		**In Network (Tier 2)**		**Out of Network**		**Combined In/Out Network**	
Deductible	*Copayment*	*Coinsurance*	*Limit*	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*

Maximum Out of Pocket for Drug EHB Benefits								Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)								
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	
								$6,350 $0	$12,700 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0	
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	
								$6,350 $0	$12,700 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0	
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	
								$4,500	$9,000			$25,000	$50,000	Not Applicab	Not Applicable	
								$2,250	$4,500			$25,000	$50,000	Not Applicab	Not Applicable	
								$2,250	$4,500			$25,000	$50,000	Not Applicab	Not Applicable	
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	
								$6,350 $0	$12,700 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0	
								$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable	

Medical EHB Deductible									Drug EHB Deductible						
In Network		In Network (Tier 2)			Out of Network		Combined In/Out Network		In Network			In Network (Tier 2)			Out of N
Family	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*

			Combined Medical and Drug EHB Deductible										Primary Care Visit to T		
Network	Combined In/Out Network		In Network			In Network (Tier 2)			Out of Network		Combined In/Out Network		Copay		
Family	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
			$6,100	$12,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$6,100 $0	$12,200 $0	0% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	No Charge $0		No Charge $0
			$6,100	$12,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$3,400	$6,800	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$3,400 $0	$6,800 $0	0% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	No Charge $0		No Charge $0
			$3,400	$6,800	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$2,600	$5,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$1,000	$2,000	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$350	$700	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$1,900	$4,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge
			$1,900 $0	$4,200 $0	0% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	No Charge $0		No Charge $0
			$1,900	$4,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	No Charge		No Charge

reat an Injury or Illness			Specialist Visit						Other Practitioner Office Visit (Nurse, Physician Assistar				
Coinsurance			Copay			Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible				0% Coinsurance after deductible		50% Coinsurance after deductible				0% Coinsurance after deductible	

nt)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)						Outpatient Surgery Physician/Surgical Services						
	Copay			Coinsurance			Copay			Coinsurance			
Out of Network	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge

Hospice Services					Non-Emergency Care When Traveling Outside the U.S.						Urgent Care Cen		
Copay		Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 2)	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

ters or Facilities			Home Health Care Services						Emergency Room Services				
Coinsurance			Copay			Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	

	Emergency Transportation/Ambulance						Inpatient Hospital Services (e.g., Hospital Stay)						
	Copay			Coinsurance			Copay			Coinsurance			
Out of Network	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge

Inpatient Physician and Surgical Services					Skilled Nursing Facility						Prenatal and P		
Copay		Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 2)	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Postnatal Care			Delivery and All Inpatient Services for Maternity Care						Mental/Behavioral Health Outpatient Services				
Coinsurance			Copay			Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible	

	Mental/Behavioral Health Inpatient Services						Substance Abuse Disorder Outpatient Services						
	Copay			Coinsurance			Copay			Coinsurance			
Out of Network	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge
0%	$0		$0	0%		0%	$0		$0	0%		0%	$0
50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge

Substance Abuse Disorder Inpatient Services					Generic Drugs						Preferred B		
Copay		Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 2)	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge
	$0	0%		0%	$0		$0	0%		0%	$0		$0
	No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		100%	No Charge		No Charge

rand Drugs			Non-Preferred Brand Drugs						Specialty Drugs				
Coinsurance			Copay			Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge	0% Coinsurance after deductible	
0%		0%	$0		$0	0%		0%	$0		$0	0%	
0% Coinsurance after deductible		100%	No Charge		No Charge	50% Coinsurance after deductible		100%	No Charge		No Charge		

Plans & Benefits Template v1.31

HIOS Issuer ID*	99248
Issuer State*	TN
Market Coverage*	Individual
Dental Only Plan*	No
TIN*	59-1031071

To use this template, please review the user guide and instructions.
You will need to save the latest version of the add-in file (PlansBenefitsAddIn.xlam) on your machine.
To create the cost share variance worksheet and enter the cost sharing amounts for both individual and SHOP (small g
To create additional Benefits Package worksheets, use the Create New Benefits Package macro.
To populate the benefits on the Benefits Package worksheet with your State EHB Standards, use the Refresh EHB mac

Plan Identifiers								
HIOS Plan ID* (Standard Component)**	**Plan Marketing Name***	**HIOS Product ID***	**HPID**	**Network ID***	**Service Area ID***	**Formulary ID***	**New/Existing Plan?***	**Plan Type***
99248TN0020005	myCigna Health Flex 5000	99248TN002	7730182962	TNN001	TNS001	TNF004	New	PPO
99248TN0020007	myCigna Health Flex 1250	99248TN002	7730182962	TNN001	TNS001	TNF004	New	PPO

roup) markets, use the Create Cost Share Variances macro.

cro.

					Plan Attributes		
Level of Coverage*	**Unique Plan Design?***	**QHP/Non-QHP***	**Notice Required for Pregnancy***	**Is a Referral Required for Specialist?***	**Specialist(s) Requiring a Referral**	**Plan Level Exclusions**	**Limited Cost Sharing Plan Variation - Est Advanced Payment**
Silver	Yes	Both	No	No			$0.00
Gold	Yes	Both	No	No			$0.00

							Stand Alone Dental Only	
HSA Eligible*	**HSA/HRA Employer Contribution**	**HSA/HRA Employer Contribution Amount**	**Child-Only Offering***	**Child Only Plan ID**	**Wellness Program Offered***	**Disease Management Programs Offered**	**EHB Apportionment for Pediatric Dental**	**Guaranteed vs. Estimated Rate**
No			Allows Adult and Child-Only		No	Diabetes		
No			Allows Adult and Child-Only		No	Diabetes		

AV Calculator Additional Benefit Design				Plan Dates		
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?	Plan Effective Date*	Plan Expiration Date	Out of Country Coverage*
				01/01/2014		Yes
				01/01/2014		Yes

Geographic Coverage				URLs	
Out of Country Coverage Description	**Out of Service Area Coverage***	**Out of Service Area Coverage Description**	**National Network***	**URL for Summary of Benefits & Coverage**	**URL for Enrollment Payment**
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		

Plan Brochure

Benefit Information			General Information				
Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay
Primary Care Visit to Treat an Injury or Illness	Yes		Covered				
Specialist Visit	Yes		Covered				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered				
Outpatient Surgery Physician/Surgical Services	Yes		Covered				
Hospice Services	Yes		Covered				
Non-Emergency Care When Traveling Outside the U.S.	Yes		Covered				
Routine Dental Services (Adult)							
Infertility Treatment	Yes		Not Covered				
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing							
Routine Eye Exam (Adult)							
Urgent Care Centers or Facilities	Yes		Covered				
Home Health Care Services	Yes		Covered	Yes	60	Visit(s) per Year	
Emergency Room Services	Yes	Yes	Covered				
Emergency Transportation/Ambulance	Yes		Covered				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes		Covered				
Inpatient Physician and Surgical Services	Yes		Covered				
Bariatric Surgery							
Cosmetic Surgery							
Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Year	
Prenatal and Postnatal Care	Yes		Covered				

			Deductible and Out of Pocket Exceptions			
Exclusions	**Explanation (text field)**	**EHB Variance Reason**	**Subject to Deductible (Tier 1)**	**Subject to Deductible (Tier 2)**	**Excluded from In Network MOOP**	**Excluded from Out of Network MOOP**
			No	No	No	No
			No	No	No	No
			No	No	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Pharmacy benefits, transplants, dialysis,			Yes	Yes	No	No
	Benchmark plan covers Family	Other Law/Regulati	Yes	Yes	No	No
			No	No	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No

Delivery and All Inpatient Services for Maternity Care	Yes		Covered		
Mental/Behavioral Health Outpatient Services	Yes		Covered	No	
Mental/Behavioral Health Inpatient Services	Yes		Covered	No	
Substance Abuse Disorder Outpatient Services	Yes		Covered	No	
Substance Abuse Disorder Inpatient Services	Yes		Covered	No	
Generic Drugs	Yes		Covered		
Preferred Brand Drugs	Yes		Covered		
Non-Preferred Brand Drugs	Yes		Covered		
Specialty Drugs	Yes		Covered		
Outpatient Rehabilitation Services	Yes		Covered		
Habilitation Services	Yes	Yes	Covered		
Chiropractic Care	Yes		Covered	Yes	20 Visit(s) per Year
Durable Medical Equipment	Yes		Covered		
Hearing Aids	Yes	Yes	Covered		
Imaging (CT/PET Scans, MRIs)	Yes		Covered		
Preventive Care/Screening/Immunization	Yes	Yes	Covered		
Routine Foot Care	Yes		Covered		
Acupuncture					
Weight Loss Programs					
Routine Eye Exam for Children	Yes		Covered	Yes	1 Visit(s) per Year
Eye Glasses for Children	Yes		Covered	Yes	1 Item(s) per Year
Dental Check-Up for Children	Yes		Not Covered		
Rehabilitative Speech Therapy	Yes		Covered	Yes	20 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered	Yes	40 Visit(s) per Year

			Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	This refers to preferred generics	Substantially Equal	No	No	No	No
	30 day supply	Substantially Equal	No	No	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Limited to members under the age of 18	1 unit per year every 3 years	Substantially Equal	Yes	Yes	No	No
			Yes	Yes	No	No
	Well Care visit limited to 1 per year except		No	No	No	No
Routine foot care for the treatment of (1) flat	Routine foot care for members with	Substantially Equal	Yes	Yes	No	No
	Plan will pay up to $30 when using an out-of-	Substantially Equal	No	No	No	No
	Benefit may also be 1 pair of contact lenses	Substantially Equal	No	No	No	No
		Dental Only Plan Available				
	Same limits and coverage apply for	Substantially Equal	Yes	Yes	No	No
	Limited to 20 visits per year occupational	Substantially Equal	Yes	Yes	No	No

Well Baby Visits and Care			Covered	
Laboratory Outpatient and Professional Services	Yes		Covered	
X-rays and Diagnostic Imaging	Yes		Covered	
Basic Dental Care – Child	Yes		Not Covered	
Orthodontia – Child	Yes		Not Covered	
Major Dental Care – Child	Yes		Not Covered	
Basic Dental Care – Adult				
Orthodontia – Adult				
Major Dental Care – Adult				
Abortion for Which Public Funding is Prohibited				
Transplant	Yes		Covered	No
Accidental Dental			Covered	
Dialysis			Covered	
Allergy Testing			Covered	
Chemotherapy			Covered	
Radiation			Covered	
Diabetes Education			Covered	
Prosthetic Devices	Yes		Covered	
Infusion Therapy			Covered	
Treatment for Temporomandibular Joint Disorders	Yes		Covered	
Nutritional Counseling			Covered	
Reconstructive Surgery	Yes	Yes	Covered	
Clinical Trials		Yes	Covered	
Diabetes Care Management		Yes	Covered	

	Additional EHB Ben	No	No	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
	Dental Only Plan Available				
	Dental Only Plan Available				
	Dental Only Plan Available				
Dollar limit only applies to	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
Limited to medically-necessary routine care	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No

Inherited Metabolic Disorder - PKU	Yes	Covered			
Off Label Prescription Drugs	Yes	Covered			
Dental Anesthesia	Yes	Covered			
Congenital Anomaly, including Cleft Lip/Palate	Yes	Covered			
Cardiac and Pulmonary Rehabilitation		Covered	Yes	36	Visit(s) per Year
Family Planning Services		Covered			
Prescription Drugs Other		Covered			

		Yes	Yes	No	No
The cost-sharing for off label prescription	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
36 Visits for Cardiac an	Additional EHB Ber	Yes	Yes	No	No
This benefit is a clarifica	Other Law/Regulati	No	No	No	No
This refers to non-prefe	Substantially Equal	No	No	No	No

Cost Sharing Reduction Information								
HIOS Plan ID* (Standard Component + Variant)	**Plan Marketing Name***	**Level of Coverage*** (Metal Level)	**CSR Variation Type***	**Issuer Actuarial Value**	**AV Calculator Output Number***	**Medical & Drug Deductibles Integrated?***	**Medical & Drug Maximum Out of Pocket Integrated?***	**Multiple In Network Tiers?***
99248TN0020005-00	myCigna Health Flex 500(	Silver	Standard Silver Off Exchange I	69.40%	68.93%	Yes	Yes	No
99248TN0020005-01		Silver	Standard Silver On Exchange I	69.40%	68.93%	Yes	Yes	No
99248TN0020005-02		Silver	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No
99248TN0020005-03		Silver	Limited Cost Sharing Plan Vari	69.40%	68.93%	Yes	Yes	No
99248TN0020005-04		Silver	73% AV Level Silver Plan	72.00%	71.47%	Yes	Yes	No
99248TN0020005-05		Silver	87% AV Level Silver Plan	86.20%	86.67%	Yes	Yes	No
99248TN0020005-06		Silver	94% AV Level Silver Plan	93.40%	93.49%	Yes	Yes	No
99248TN0020007-00	myCigna Health Flex 125(	Gold	Standard Gold Off Exchange P	80.60%	81.14%	Yes	Yes	No
99248TN0020007-01		Gold	Standard Gold On Exchange P	80.60%	81.14%	Yes	Yes	No
99248TN0020007-02		Gold	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No
99248TN0020007-03		Gold	Limited Cost Sharing Plan Vari	80.60%	81.14%	Yes	Yes	No

		SBC Scenario								Ma	
		Having a Baby				Having Diabetes				In Network	
1st Tier Utilization*	2nd Tier Utilization	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Individual*	*Family*
100%											
100%											
100%											
100%											
100%											
100%											
100%											
100%											
100%											
100%											

aximum Out of Pocket for Medical EHB Benefits						Maximum Out of Pocket for Drug EHB Benefits							
In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)								Medical EHB Deductible					
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network			In Network (Tier 2)		
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*
$5,000	$10,000			$25,000	$50,000	Not Applicab	Not Applicable						
$5,000 $0	$10,000 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0						
$5,000	$10,000			$25,000	$50,000	Not Applicab	Not Applicable						
$4,250	$8,500			$25,000	$50,000	Not Applicab	Not Applicable						
$1,450	$2,900			$25,000	$50,000	Not Applicab	Not Applicable						
$600	$1,200			$25,000	$50,000	Not Applicab	Not Applicable						
$2,500	$5,000			$25,000	$50,000	Not Applicab	Not Applicable						
$2,500 $0	$5,000 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0						
$2,500	$5,000			$25,000	$50,000	Not Applicab	Not Applicable						

				Drug EHB Deductible											
Out of Network		**Combined In/Out Network**		**In Network**			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*

Combined Medical and Drug EHB Deductible										Primary Care Visit to T		
In Network			In Network (Tier 2)			Out of Network		Combined In/Out Network		Copay		
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$5,000	$10,000	0%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$5,000 $0	$10,000 $0	0% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	$30 $0		No Charge $0
$5,000	$10,000	0%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$4,250	$8,500	0%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$1,450	$2,900	0%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$600	$1,200	0%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$1,250	$2,500	20%				$12,500	$25,000	Not Applicab	Not Applicab	$20		No Charge
$1,250 $0	$2,500 $0	20% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	$20 $0		No Charge $0
$1,250	$2,500	20%				$12,500	$25,000	Not Applicab	Not Applicab	$20		No Charge

reat an Injury or Illness			Specialist Visit						Other Practitioner Office Visit		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
$0		0%	$0		$0	$0		0%	$0		$0
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
No Charge		50% Coinsurance after deductible	$60		No Charge	No Charge		50% Coinsurance after deductible	$60		No Charge
No Charge		50% Coinsurance after deductible	$40		No Charge	No Charge		50% Coinsurance after deductible	$40		No Charge
No Charge		50% Coinsurance after deductible	$40		No Charge	No Charge		50% Coinsurance after deductible	$40		No Charge
$0		0%	$0		$0	$0		0%	$0		$0
No Charge		50% Coinsurance after deductible	$40		No Charge	No Charge		50% Coinsurance after deductible	$40		No Charge

t (Nurse, Physician Assistant)			Outpatient Facility Fee (e.g., Ambulatory Surgery Center)						Outpatient Surgery Phys		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
$0		0%	$0		$0	0%		0%	$0		$0
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
No Charge		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
$0		0%	$0		$0	0%		0%	$0		$0
No Charge		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

sician/Surgical Services			Hospice Services						Non-Emergency Care When		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Traveling Outside the U.S.			Urgent Care Centers or Facilities						Home Health		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	$0		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	$0		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge

Care Services			Emergency Room Services						Emergency Transpo		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

ortation/Ambulance			Inpatient Hospital Services (e.g., Hospital Stay)						Inpatient Physician a		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

nd Surgical Services			Skilled Nursing Facility						Prenatal and F		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Postnatal Care			Delivery and All Inpatient Services for Maternity Care						Mental/Behavioral Heal		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

lth Outpatient Services			Mental/Behavioral Health Inpatient Services						Substance Abuse Disor		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

der Outpatient Services			Substance Abuse Disorder Inpatient Services						Generic		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	0% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
20% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	20% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge

c Drugs			Preferred Brand Drugs						Non-Preferred		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
$0		0%	$0		$0	$0		0%	$0		$0
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$20		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge
$0		0%	$0		$0	$0		0%	$0		$0
No Charge		100% Coinsurance after deductible	$45		No Charge	No Charge		100% Coinsurance after deductible	No Charge		No Charge

l Brand Drugs			Specialty Drugs				
Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
0%		0%	$0		$0	0%	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	
0%		0%	$0		$0	0%	
50% Coinsurance after deductible		100% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible	

Plans & Benefits Template v1.31

HIOS Issuer ID*	99248
Issuer State*	TN
Market Coverage*	Individual
Dental Only Plan*	No
TIN*	59-1031071

To use this template, please review the user guide and instructions.
You will need to save the latest version of the add-in file (PlansBenefitsAddIn.xlam) on your machine.
To create the cost share variance worksheet and enter the cost sharing amounts for both individual and SHOP (small g
To create additional Benefits Package worksheets, use the Create New Benefits Package macro.
To populate the benefits on the Benefits Package worksheet with your State EHB Standards, use the Refresh EHB mac

Plan Identifiers								
HIOS Plan ID* (Standard Component)**	**Plan Marketing Name***	**HIOS Product ID***	**HPID**	**Network ID***	**Service Area ID***	**Formulary ID***	**New/Existing Plan?***	**Plan Type***
99248TN0020002	myCigna Health Flex 5500	99248TN002	7730182962	TNN001	TNS001	TNF002	New	PPO

roup) markets, use the Create Cost Share Variances macro.

cro.

					Plan Attributes		
Level of Coverage*	**Unique Plan Design?***	**QHP/Non-QHP***	**Notice Required for Pregnancy***	**Is a Referral Required for Specialist?***	**Specialist(s) Requiring a Referral**	**Plan Level Exclusions**	**Limited Cost Sharing Plan Variation - Est Advanced Payment**
Bronze	Yes	Both	No	No			$0.00

							Stand Alone Dental Only	
HSA Eligible*	**HSA/HRA Employer Contribution**	**HSA/HRA Employer Contribution Amount**	**Child-Only Offering***	**Child Only Plan ID**	**Wellness Program Offered***	**Disease Management Programs Offered**	**EHB Apportionment for Pediatric Dental**	**Guaranteed vs. Estimated Rate**
No			Allows Adult and Child-Only		No	Diabetes		

AV Calculator Additional Benefit Design				*Plan Dates*		
Maximum Coinsurance for Specialty Drugs	**Maximum Number of Days for Charging an Inpatient Copay?**	**Begin Primary Care Cost-Sharing After a Set Number of Visits?**	**Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?**	**Plan Effective Date***	**Plan Expiration Date**	**Out of Country Coverage***
				01/01/2014		Yes

Geographic Coverage				URLs	
Out of Country Coverage Description	**Out of Service Area Coverage***	**Out of Service Area Coverage Description**	**National Network***	**URL for Summary of Benefits & Coverage**	**URL for Enrollment Payment**
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		

Plan Brochure

Benefit Information			General Information				
Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay
Primary Care Visit to Treat an Injury or Illness	Yes		Covered				
Specialist Visit	Yes		Covered				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered				
Outpatient Surgery Physician/Surgical Services	Yes		Covered				
Hospice Services	Yes		Covered				
Non-Emergency Care When Traveling Outside the U.S.	Yes		Covered				
Routine Dental Services (Adult)							
Infertility Treatment	Yes		Not Covered				
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing							
Routine Eye Exam (Adult)							
Urgent Care Centers or Facilities	Yes		Covered				
Home Health Care Services	Yes		Covered	Yes	60	Visit(s) per Year	
Emergency Room Services	Yes	Yes	Covered				
Emergency Transportation/Ambulance	Yes		Covered				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes		Covered				
Inpatient Physician and Surgical Services	Yes		Covered				
Bariatric Surgery							
Cosmetic Surgery							
Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Year	
Prenatal and Postnatal Care	Yes		Covered				

			Deductible and Out of Pocket Exceptions			
Exclusions	**Explanation (text field)**	**EHB Variance Reason**	**Subject to Deductible (Tier 1)**	**Subject to Deductible (Tier 2)**	**Excluded from In Network MOOP**	**Excluded from Out of Network MOOP**
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Pharmacy benefits, transplants, dialysis,			Yes	Yes	No	No
	Benchmark plan covers Family	Other Law/Regulati	Yes	Yes	No	No
			No	No	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No

Delivery and All Inpatient Services for Maternity Care	Yes		Covered		
Mental/Behavioral Health Outpatient Services	Yes		Covered	No	
Mental/Behavioral Health Inpatient Services	Yes		Covered	No	
Substance Abuse Disorder Outpatient Services	Yes		Covered	No	
Substance Abuse Disorder Inpatient Services	Yes		Covered	No	
Generic Drugs	Yes		Covered		
Preferred Brand Drugs	Yes		Covered		
Non-Preferred Brand Drugs	Yes		Covered		
Specialty Drugs	Yes		Covered		
Outpatient Rehabilitation Services	Yes		Covered		
Habilitation Services	Yes	Yes	Covered		
Chiropractic Care	Yes		Covered	Yes	20 Visit(s) per Year
Durable Medical Equipment	Yes		Covered		
Hearing Aids	Yes	Yes	Covered		
Imaging (CT/PET Scans, MRIs)	Yes		Covered		
Preventive Care/Screening/Immunization	Yes	Yes	Covered		
Routine Foot Care	Yes		Covered		
Acupuncture					
Weight Loss Programs					
Routine Eye Exam for Children	Yes		Covered	Yes	1 Visit(s) per Year
Eye Glasses for Children	Yes		Covered	Yes	1 Item(s) per Year
Dental Check-Up for Children	Yes		Not Covered		
Rehabilitative Speech Therapy	Yes		Covered	Yes	20 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered	Yes	40 Visit(s) per Year

			Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Refers to preferred generics only; 30 day	Substantially Equal	No	No	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Limited to members under the age of 18	1 unit per year every 3 years	Substantially Equal	Yes	Yes	No	No
			Yes	Yes	No	No
	Well Care visit limited to 1 per year except		No	No	No	No
Routine foot care for the treatment of (1) flat	Routine foot care for members with	Substantially Equal	Yes	Yes	No	No
	Plan will pay up to $30 when using an out-of-	Substantially Equal	No	No	No	No
	Benefit may also be 1 pair of contact lenses	Substantially Equal	No	No	No	No
		Dental Only Plan Available				
	Same limits and coverage apply for	Substantially Equal	Yes	Yes	No	No
	Limited to 20 visits per year occupational	Substantially Equal	Yes	Yes	No	No

Well Baby Visits and Care			Covered	
Laboratory Outpatient and Professional Services	Yes		Covered	
X-rays and Diagnostic Imaging	Yes		Covered	
Basic Dental Care – Child	Yes		Not Covered	
Orthodontia – Child	Yes		Not Covered	
Major Dental Care – Child	Yes		Not Covered	
Basic Dental Care – Adult				
Orthodontia – Adult				
Major Dental Care – Adult				
Abortion for Which Public Funding is Prohibited				
Transplant	Yes		Covered	No
Accidental Dental			Covered	
Dialysis			Covered	
Allergy Testing			Covered	
Chemotherapy			Covered	
Radiation			Covered	
Diabetes Education			Covered	
Prosthetic Devices	Yes		Covered	
Infusion Therapy			Covered	
Treatment for Temporomandibular Joint Disorders	Yes		Covered	
Nutritional Counseling			Covered	
Reconstructive Surgery	Yes	Yes	Covered	
Clinical Trials		Yes	Covered	
Diabetes Care Management		Yes	Covered	

	Additional EHB Ben	No	No	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
	Dental Only Plan Available				
	Dental Only Plan Available				
	Dental Only Plan Available				
Dollar limit only applies to	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
Limited to medically-necessary routine care	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No

Inherited Metabolic Disorder - PKU	Yes	Covered			
Off Label Prescription Drugs	Yes	Covered			
Dental Anesthesia	Yes	Covered			
Congenital Anomaly, including Cleft Lip/Palate	Yes	Covered			
Cardiac and Pulmonary Rehabilitation		Covered	Yes	36	Visit(s) per Year
Family Planning Services		Covered			
Prescription Drugs Other		Covered			

		Yes	Yes	No	No
The cost-sharing for off label prescription	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
36 Visits for Cardiac an	Additional EHB Ber	Yes	Yes	No	No
This benefit is a clarific	Other Law/Regulati	No	No	No	No
Non-preferred generics	Substantially Equal	Yes	Yes	No	No

Cost Sharing Reduction Information								
HIOS Plan ID* (Standard Component + Variant)	**Plan Marketing Name***	**Level of Coverage*** (Metal Level)	**CSR Variation Type***	**Issuer Actuarial Value**	**AV Calculator Output Number***	**Medical & Drug Deductibles Integrated?***	**Medical & Drug Maximum Out of Pocket Integrated?***	**Multiple In Network Tiers?***
99248TN0020002-00	myCigna Health Flex 550(	Bronze	Standard Bronze Off Exchange	60.30%	63.93%	Yes	Yes	No
99248TN0020002-01		Bronze	Standard Bronze On Exchange	60.30%	63.93%	Yes	Yes	No
99248TN0020002-02		Bronze	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No
99248TN0020002-03		Bronze	Limited Cost Sharing Plan Vari	60.30%	63.93%	Yes	Yes	No

		SBC Scenario								Ma	
		Having a Baby				Having Diabetes				In Network	
1st Tier Utilization*	2nd Tier Utilization	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Individual*	*Family*
100%											
100%											
100%											
100%											

aximum Out of Pocket for Medical EHB Benefits						Maximum Out of Pocket for Drug EHB Benefits							
In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)								Medical EHB Deductible					
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network			In Network (Tier 2)		
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*
$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable						
$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable						
$0	$0			$0	$0	$0	$0						
$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable						

				Drug EHB Deductible										
Out of Network		**Combined In/Out Network**		**In Network**			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**		
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	

Combined Medical and Drug EHB Deductible										Primary Care Visit to T		
In Network			In Network (Tier 2)			Out of Network		Combined In/Out Network		Copay		
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$5,500	$11,000	40%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$5,500	$11,000	40%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$0	$0	0%				$0	$0	$0	$0	$0		$0
$5,500	$11,000	40%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge

reat an Injury or Illness			Specialist Visit						Other Practitioner Office Visit		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge

t (Nurse, Physician Assistant)			Outpatient Facility Fee (e.g., Ambulatory Surgery Center)						Outpatient Surgery Phys		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

sician/Surgical Services			Hospice Services						Non-Emergency Care When		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Traveling Outside the U.S.			Urgent Care Centers or Facilities						Home Health		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	$0		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge

Care Services			Emergency Room Services						Emergency Transpo		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

ortation/Ambulance			Inpatient Hospital Services (e.g., Hospital Stay)						Inpatient Physician a		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

nd Surgical Services			Skilled Nursing Facility						Prenatal and F		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Postnatal Care			Delivery and All Inpatient Services for Maternity Care						Mental/Behavioral Heal		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

lth Outpatient Services			Mental/Behavioral Health Inpatient Services						Substance Abuse Disor		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

der Outpatient Services			Substance Abuse Disorder Inpatient Services						Generic		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
40% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	40% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge

c Drugs			Preferred Brand Drugs						Non-Preferred		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		100%	No Charge		No Charge	40% Coinsurance after deductible		100%	No Charge		No Charge
No Charge		100%	No Charge		No Charge	40% Coinsurance after deductible		100%	No Charge		No Charge
$0		0%	$0		$0	0%		0%	$0		$0
No Charge		100%	No Charge		No Charge	40% Coinsurance after deductible		100%	No Charge		No Charge

l Brand Drugs			Specialty Drugs				
Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	
0%		0%	$0		$0	0%	
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	

Plans & Benefits Template v1.31

HIOS Issuer ID*	99248
Issuer State*	TN
Market Coverage*	Individual
Dental Only Plan*	No
TIN*	59-1031071

To use this template, please review the user guide and instructions.
You will need to save the latest version of the add-in file (PlansBenefitsAddIn.xlam) on your machine.
To create the cost share variance worksheet and enter the cost sharing amounts for both individual and SHOP (small g
To create additional Benefits Package worksheets, use the Create New Benefits Package macro.
To populate the benefits on the Benefits Package worksheet with your State EHB Standards, use the Refresh EHB mac

Plan Identifiers								
HIOS Plan ID* (Standard Component)**	**Plan Marketing Name***	**HIOS Product ID***	**HPID**	**Network ID***	**Service Area ID***	**Formulary ID***	**New/Existing Plan?***	**Plan Type***
99248TN0020004	myCigna Health Flex 1500	99248TN002	7730182962	TNN001	TNS001	TNF003	New	PPO

roup) markets, use the Create Cost Share Variances macro.

cro.

					Plan Attributes		
Level of Coverage*	**Unique Plan Design?***	**QHP/Non-QHP***	**Notice Required for Pregnancy***	**Is a Referral Required for Specialist?***	**Specialist(s) Requiring a Referral**	**Plan Level Exclusions**	**Limited Cost Sharing Plan Variation - Est Advanced Payment**
Silver	Yes	Both	No	No			$0.00

							Stand Alone Dental Only	
HSA Eligible*	**HSA/HRA Employer Contribution**	**HSA/HRA Employer Contribution Amount**	**Child-Only Offering***	**Child Only Plan ID**	**Wellness Program Offered***	**Disease Management Programs Offered**	**EHB Apportionment for Pediatric Dental**	**Guaranteed vs. Estimated Rate**
No			Allows Adult and Child-Only		No	Diabetes		

AV Calculator Additional Benefit Design				*Plan Dates*		
Maximum Coinsurance for Specialty Drugs	**Maximum Number of Days for Charging an Inpatient Copay?**	**Begin Primary Care Cost-Sharing After a Set Number of Visits?**	**Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?**	**Plan Effective Date***	**Plan Expiration Date**	**Out of Country Coverage***
				01/01/2014		Yes

Geographic Coverage				URLs	
Out of Country Coverage Description	**Out of Service Area Coverage***	**Out of Service Area Coverage Description**	**National Network***	**URL for Summary of Benefits & Coverage**	**URL for Enrollment Payment**
All services except exclusions listed in Benefits Package.	Yes	Some services excluded. See plan documents.	Yes		

Plan Brochure

Benefit Information			General Information				
Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay
Primary Care Visit to Treat an Injury or Illness	Yes		Covered				
Specialist Visit	Yes		Covered				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered				
Outpatient Surgery Physician/Surgical Services	Yes		Covered				
Hospice Services	Yes		Covered				
Non-Emergency Care When Traveling Outside the U.S.	Yes		Covered				
Routine Dental Services (Adult)							
Infertility Treatment	Yes		Not Covered				
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing							
Routine Eye Exam (Adult)							
Urgent Care Centers or Facilities	Yes		Covered				
Home Health Care Services	Yes		Covered	Yes	60	Visit(s) per Year	
Emergency Room Services	Yes	Yes	Covered				
Emergency Transportation/Ambulance	Yes		Covered				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes		Covered				
Inpatient Physician and Surgical Services	Yes		Covered				
Bariatric Surgery							
Cosmetic Surgery							
Skilled Nursing Facility	Yes		Covered	Yes	60	Days per Year	
Prenatal and Postnatal Care	Yes		Covered				

			Deductible and Out of Pocket Exceptions			
Exclusions	**Explanation (text field)**	**EHB Variance Reason**	**Subject to Deductible (Tier 1)**	**Subject to Deductible (Tier 2)**	**Excluded from In Network MOOP**	**Excluded from Out of Network MOOP**
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
	First two visits copay applies. Coinsurance	Substantially Equal	No	No	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Pharmacy benefits, transplants, dialysis,			Yes	Yes	No	No
	Benchmark plan covers Family	Other Law/Regulati	Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No

Delivery and All Inpatient Services for Maternity Care	Yes		Covered		
Mental/Behavioral Health Outpatient Services	Yes		Covered	No	
Mental/Behavioral Health Inpatient Services	Yes		Covered	No	
Substance Abuse Disorder Outpatient Services	Yes		Covered	No	
Substance Abuse Disorder Inpatient Services	Yes		Covered	No	
Generic Drugs	Yes		Covered		
Preferred Brand Drugs	Yes		Covered		
Non-Preferred Brand Drugs	Yes		Covered		
Specialty Drugs	Yes		Covered		
Outpatient Rehabilitation Services	Yes		Covered		
Habilitation Services	Yes	Yes	Covered		
Chiropractic Care	Yes		Covered	Yes	20 Visit(s) per Year
Durable Medical Equipment	Yes		Covered		
Hearing Aids	Yes	Yes	Covered		
Imaging (CT/PET Scans, MRIs)	Yes		Covered		
Preventive Care/Screening/Immunization	Yes	Yes	Covered		
Routine Foot Care	Yes		Covered		
Acupuncture					
Weight Loss Programs					
Routine Eye Exam for Children	Yes		Covered	Yes	1 Visit(s) per Year
Eye Glasses for Children	Yes		Covered	Yes	1 Item(s) per Year
Dental Check-Up for Children	Yes		Not Covered		
Rehabilitative Speech Therapy	Yes		Covered	Yes	20 Visit(s) per Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes		Covered	Yes	40 Visit(s) per Year

			Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Limits do not apply due to	Other Law/Regulati	Yes	Yes	No	No
	Refers to preferred generics, 30 day	Substantially Equal	No	No	No	No
	30 day supply	Substantially Equal	No	No	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	30 day supply	Substantially Equal	Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
	Quantitative limit units apply, see EHB		Yes	Yes	No	No
			Yes	Yes	No	No
			Yes	Yes	No	No
Limited to members under the age of 18	1 unit per year every 3 years	Substantially Equal	Yes	Yes	No	No
			Yes	Yes	No	No
	Well Care visit limited to 1 per year except		No	No	No	No
Routine foot care for the treatment of (1) flat	Routine foot care for members with	Substantially Equal	Yes	Yes	No	No
	Plan will pay up to $30 when using an out-of-	Substantially Equal	No	No	No	No
	Benefit may also be 1 pair of contact lenses	Substantially Equal	No	No	No	No
		Dental Only Plan Available				
	Same limits and coverage apply for	Substantially Equal	Yes	Yes	No	No
	Limited to 20 visits per year occupational	Substantially Equal	Yes	Yes	No	No

Well Baby Visits and Care			Covered	
Laboratory Outpatient and Professional Services	Yes		Covered	
X-rays and Diagnostic Imaging	Yes		Covered	
Basic Dental Care – Child	Yes		Not Covered	
Orthodontia – Child	Yes		Not Covered	
Major Dental Care – Child	Yes		Not Covered	
Basic Dental Care – Adult				
Orthodontia – Adult				
Major Dental Care – Adult				
Abortion for Which Public Funding is Prohibited				
Transplant	Yes		Covered	No
Accidental Dental			Covered	
Dialysis			Covered	
Allergy Testing			Covered	
Chemotherapy			Covered	
Radiation			Covered	
Diabetes Education			Covered	
Prosthetic Devices	Yes		Covered	
Infusion Therapy			Covered	
Treatment for Temporomandibular Joint Disorders	Yes		Covered	
Nutritional Counseling			Covered	
Reconstructive Surgery	Yes	Yes	Covered	
Clinical Trials		Yes	Covered	
Diabetes Care Management		Yes	Covered	

	Additional EHB Ben	No	No	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
	Dental Only Plan Available				
	Dental Only Plan Available				
	Dental Only Plan Available				
Dollar limit only applies to	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	Yes	Yes	No	No
		Yes	Yes	No	No
Limited to medically-necessary routine care	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No

Inherited Metabolic Disorder - PKU	Yes	Covered
Off Label Prescription Drugs	Yes	Covered
Dental Anesthesia	Yes	Covered
Congenital Anomaly, including Cleft Lip/Palate	Yes	Covered
Cardiac and Pulmonary Rehabilitation		Covered
Family Planning Services		Covered
Prescription Drugs Other		Covered

		Yes	Yes	No	No
The cost-sharing for off label prescription	Substantially Equal	Yes	Yes	No	No
		Yes	Yes	No	No
		Yes	Yes	No	No
	Additional EHB Ben	No	No	No	No
This benefit is a clarifica	Other Law/Regulati	Yes	Yes	No	No
This refers to non-prefe	Substantially Equal	No	No	No	No

Cost Sharing Reduction Information								
HIOS Plan ID* (Standard Component + Variant)	**Plan Marketing Name***	**Level of Coverage*** (Metal Level)	**CSR Variation Type***	**Issuer Actuarial Value**	**AV Calculator Output Number***	**Medical & Drug Deductibles Integrated?***	**Medical & Drug Maximum Out of Pocket Integrated?***	**Multiple In Network Tiers?***
99248TN0020004-00	myCigna Health Flex 150(	Silver	Standard Silver Off Exchange I	69.10%	70.92%	Yes	Yes	No
99248TN0020004-01		Silver	Standard Silver On Exchange I	69.10%	70.92%	Yes	Yes	No
99248TN0020004-02		Silver	Zero Cost Sharing Plan Variati	100.00%	100.00%	Yes	Yes	No
99248TN0020004-03		Silver	Limited Cost Sharing Plan Vari	69.10%	70.92%	Yes	Yes	No
99248TN0020004-04		Silver	73% AV Level Silver Plan	72.60%	74.25%	Yes	Yes	No
99248TN0020004-05		Silver	87% AV Level Silver Plan	86.30%	86.78%	Yes	Yes	No
99248TN0020004-06		Silver	94% AV Level Silver Plan	93.40%	93.52%	Yes	Yes	No

		SBC Scenario								Ma	
		Having a Baby				Having Diabetes				In Network	
1st Tier Utilization*	2nd Tier Utilization	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Deductible*	*Copayment*	*Coinsurance*	*Limit*	*Individual*	*Family*
100%											
100%											
100%											
100%											
100%											
100%											

aximum Out of Pocket for Medical EHB Benefits						Maximum Out of Pocket for Drug EHB Benefits							
In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)								Medical EHB Deductible					
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network			In Network (Tier 2)		
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*
$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable						
$6,350 $0	$12,700 $0			$25,000 $0	$50,000 $0	Not Applicab $0	Not Applicable $0						
$6,350	$12,700			$25,000	$50,000	Not Applicab	Not Applicable						
$4,250	$8,500			$25,000	$50,000	Not Applicab	Not Applicable						
$1,400	$2,800			$25,000	$50,000	Not Applicab	Not Applicable						
$575	$1,150			$25,000	$50,000	Not Applicab	Not Applicable						

				Drug EHB Deductible									
Out of Network		**Combined In/Out Network**		**In Network**			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*

Combined Medical and Drug EHB Deductible										Primary Care Visit to T		
In Network			In Network (Tier 2)			Out of Network		Combined In/Out Network		Copay		
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$1,500	$3,000	30%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$1,500 $0	$3,000 $0	30% 0%				$12,500 $0	$25,000 $0	Not Applicab $0	Not Applicab $0	$30 $0		No Charge $0
$1,500	$3,000	30%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$1,500	$3,000	30%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$725	$1,450	30%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge
$200	$400	30%				$12,500	$25,000	Not Applicab	Not Applicab	$30		No Charge

reat an Injury or Illness			Specialist Visit						Other Practitioner Office Visit		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$60		No Charge

t (Nurse, Physician Assistant)			Outpatient Facility Fee (e.g., Ambulatory Surgery Center)						Outpatient Surgery Phys		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

sician/Surgical Services			Hospice Services						Non-Emergency Care When		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Traveling Outside the U.S.			Urgent Care Centers or Facilities						Home Health		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	$0		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$75		No Charge	No Charge		50% Coinsurance after deductible	No Charge		No Charge

Care Services			Emergency Room Services						Emergency Transpo		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

ortation/Ambulance			Inpatient Hospital Services (e.g., Hospital Stay)						Inpatient Physician a		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

nd Surgical Services			Skilled Nursing Facility						Prenatal and F		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	$0 Copay per Day		$0 Copay per Day	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

Postnatal Care			Delivery and All Inpatient Services for Maternity Care						Mental/Behavioral Heal		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

lth Outpatient Services			Mental/Behavioral Health Inpatient Services						Substance Abuse Disor		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge

der Outpatient Services			Substance Abuse Disorder Inpatient Services						Generic		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
0%		0%	$0		$0	0%		0%	$0		$0
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge
30% Coinsurance after deductible		50% Coinsurance after deductible	No Charge		No Charge	30% Coinsurance after deductible		50% Coinsurance after deductible	$4		No Charge

c Drugs			Preferred Brand Drugs						Non-Preferred		
Coinsurance			Copay			Coinsurance			Copay		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
No Charge		100%	$60		No Charge	No Charge		100%	No Charge		No Charge
No Charge		100%	$60		No Charge	No Charge		100%	No Charge		No Charge
$0		0%	$0		$0	$0		0%	$0		$0
No Charge		100%	$60		No Charge	No Charge		100%	No Charge		No Charge
No Charge		100%	$60		No Charge	No Charge		100%	No Charge		No Charge
No Charge		100%	$45		No Charge	No Charge		100%	No Charge		No Charge
No Charge		100%	$20		No Charge	No Charge		100%	No Charge		No Charge

l Brand Drugs			Specialty Drugs				
Coinsurance			Copay			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	
0%		0%	$0		$0	0%	
50% Coinsurance after deductible		100% No Charge			No Charge	40% Coinsurance after deductible	
50% Coinsurance after deductible		100% No Charge			No Charge	30% Coinsurance after deductible	
50% Coinsurance after deductible		100% No Charge			No Charge	30% Coinsurance after deductible	
50% Coinsurance after deductible		100% No Charge			No Charge	30% Coinsurance after deductible	

Lauren Danziger, FSA, MAAA
Actuary
Cigna HealthCare Pricing

July 12, 2013

Routing C5PRC
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.6586
Lauren.Danziger@Cigna.com

Mr. Art Lucker
Tennessee Department of Commerce and Insurance
Actuarial Section, 4th Floor
500 James Robertson Parkway
Nashville, Tennessee 37243-1130

RE: Cigna Health and Life Insurance Company
NAIC Company ID#: 67369
Rate Filing for Individual Health Plans
INDTNCH042013 – Effective 01/01/2014
State Tracking #: H-130551

Dear Mr. Lucker,

In response to your initial objection letter dated June 30, 2013, this letter provides additional information for your consideration regarding our filing H-130551.

The TN DOI's comments and questions regarding Cigna Health and Life Insurance Company's (CHLIC) filing are addressed below:

Objection 1

A. Credibility Manual Rate

1. *Please show the development of the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.*

As referenced in Section 6a of the Actuarial Memorandum, the source data used to generate the Manual Rate is trended national group experience adjusted for state and market specific differences. The experience for the national group book of business is deemed appropriate to be used for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are more similar to the benefits required to be ACA compliant than any other experience available.

The development of the credibility manual in URRT worksheet 1, section II is different from our internal development of the manual rate. Our trended national group experience is adjusted for state and market specific differences and then additional adjustments for morbidity, demographics, essential health benefits, and network savings are applied in aggregate to the total claim cost. This differs from the

development in URRT worksheet 1, section II which requires issuers to build up the final rate from utilization and average allowed cost per unit of service by benefit category. While our manual rate is built from utilization and cost assumptions for these specific categories, there are many additional adjustments made in aggregate that do not make it possible for an exact build up by service category split into utilization and average costs. In order to show this build up in URRT worksheet 1, our aggregate manual rate is scaled by benefit category using internal utilization and cost factors. The aforementioned adjustments are applied to each average cost/service by benefit category as discussed below.

2. *Regarding the adjustments made to the data, the actuarial memorandum states that a 5% load was added to the manual rate to account for the difference in morbidity risk of the population underlying the Manual Rate and the anticipated population of the Individual market in 2014. Please quantify the contributory effect that each of the following components has on the 5% morbidity load and please provide the actuarial basis for your quantification:*
    a. *The influx of members from high-risk pools, HIPAA and conversion policies;*
    b. *The influx of new entrants who were previously uninsured;*
    c. *Plan selection;*
    d. *Pent-up demand;*
    e. *Non-Smoker population adjustment;*
    f. *CSR plan induced utilization;*

    Additionally, please show how the 5% morbidity load is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.

The Affordable Care Act introduces unprecedented changes to the individual marketplace. In consideration of the changes and uncertainty of health risks of the participating individuals on the market due to the individual mandate and guaranteed issue, with limited internal and external information on the topic, we developed the 5% morbidity load after qualitatively and quantitatively examining the following key data points:

- The Society of Actuaries' study on the "Cost of the Future Newly Insured under the ACA" suggested that the medical cost of the individual market will increase by 32% under ACA on a nationwide basis. However, it also revealed that such a morbidity change would vary dramatically by state and by states' decisions to expand Medicaid, and the results in the study reflected a 2016 view of the market when all ACA provisions are in place. Therefore, in leveraging the SOA's findings, we focused on only the ten states where Cigna conducts individual business in, conducted sensitivity testing to key assumptions in the SOA's study, and adjusted the SOA's results based on our view of the market in 2014.
- We also utilized the Episode Risk Group (ERG) Risk Score data maintained by Cigna's business intelligence team. ERG is a widely-used health risk assessment tool in the industry and it relies on medical treatment categories to measure the health risks of the covered population. We were able to compare the risk levels of the individual business compared to large group experience, which reflects the impact of medical underwriting currently in place. Such an impact will be removed due to guaranteed issue starting in 2014.
- We also took into consideration the uncertainty on the cost of the previously uninsured population, how different population groups would react under ACA, and how much impact the pent-up demand will generate.

The 5% morbidity load was in consideration of the components listed in the Actuarial Memorandum but we did not develop this load by building up each component separately, therefore we do not have it split out by individual component.

As referenced in the response to the first objection, this adjustment is applied to the average allowed cost per unit of service by benefit category for the credibility manual shown in URRT worksheet 1, section II.

3. *Regarding the demographic adjustment made to the data, please quantify the adjustment that was made to reflect the impact of compression of age slopes as wells as to account for the different distribution by age in the 2014 individual market. Please show how you developed this quantification. Additionally, please show how the demographic adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.*

As referenced in Part 6b of the Actuarial Memorandum, the experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, a minimal adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2014 individual market as opposed to the distribution by age reflected in the data underlying the Manual Rate.

This quantification was developed by making a revenue neutral adjustment between our current age/gender slope and the 2014 Federal age slope based on our membership distribution assumptions. We further modified this adjustment based on our expected 2014 distribution by age per the Society of Actuaries sponsored study "Cost of the Future Newly Insured under the ACA" to arrive at our final demographic adjustment of 1.04.

As referenced in the response to the first objection, this adjustment is applied to the average allowed cost per unit of service by benefit category for the credibility manual shown in URRT worksheet 1, section II.

4. *Regarding the impact of EHB adjustment made to the data, please show how the 0.2% load for this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.*

Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a 0.2% load. The 0.2% load captures additional adjustments for Physical Therapy, Occupational Therapy, and Speech Therapy rehabilitation. While this EHB is partially captured in our underlying experience, the 0.2% represents an adjustment to capture slight differences in the benefit in the underlying experience.

As referenced in the response to the first objection, this adjustment is applied to the average allowed cost per unit of service by benefit category for the credibility manual shown in URRT worksheet 1, section II.

5. *Regarding the Network Savings adjustment made to the data, please show how the 5.2% decrement representing this adjustment was determined. Additionally, please show how this adjustment is reflected in the utilization per 1000 and average cost/service figures by benefit category for the credibility manual shown in URRT worksheet 1, section II.*

CHLIC's underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. The estimated savings of the new provider networks vary by geographic region, but are incorporated into the Manual Rate based on assumed enrollment by region as an average 5.2% decrement. This decrement represents the average savings for

new provider networks in the Greater Memphis, Greater Nashville, and Greater Chattanooga rating areas weighted by our expected membership distribution.

As referenced in the response to the first objection, this adjustment is applied to the average allowed cost per unit of service by benefit category for the credibility manual shown in URRT worksheet 1, section II.

B. Paid to Allowed Ratio

1. *Please demonstrate the development of the overall anticipated paid to allowed average factor of 71.6%*

As referenced in Section 8 of the Actuarial Memorandum, the expected cost-sharing ratio for each benefit plan is calculated by using group experience over the experience period (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then utilized to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-share estimates. The expected distribution of business by benefit plan originates from CHLIC's internal estimates.

The Paid to Allowed Average Factor can also be derived from the amounts shown in Section IV of worksheet 2 of the URRT. The Paid to Allowed Factor is 1 minus the quotient of Allowed Claims which are not the issuer's obligation less Net Amount of Reinsurance divided by the Total Allowed Claims (TAC). Please see the demonstration below.

Demonstration of Paid to Allowed Average Factor	
	Product ID
	99248TN002
Total Allowed Claims (TAC) (Cell F86 Wksh 2)	$11,780,415
Allowed Claims which are not the issuer's obligation (Cell F90 Wksh 2)	$4,236,328
Net Amt of Rein (Cell F95 Wksh 2)	$892,003
Paid to Allowed Factor (Cell V43 Wksh 1)	0.716

C. Risk Adjustment & Reinsurance

1. *Please demonstrate the development of your estimate that ACA reinsurance recoveries net of reinsurance premiums will cover 12.5% of paid claims*

To estimate reinsurance contributions, an annual contribution of $63 per covered life is assumed. Reinsurance payments have been estimated using a representative sample of nationwide group claims data. This data consisted of member-level claims data from October 2011 through November 2012 trended to a 2014 basis, using 11% annual trend. Total claims for each member are calculated as the sum of the claims for each member over the one year period for which the data was pulled, trended forward. The reinsurance payments are calculated using the federally established formula of 80% of claims between $60,000 and $250,000. This formula was applied to the total claims for each member. From this member-level data, we were able to determine the total amount of claims and the total amount of reinsurance payments.

In our analysis, it is not anticipated that the increased morbidity risk will cause a higher distribution of claims to fall within or outside the parameters set for the reinsurance program. We believe that this

claims data is representative of the annual distribution of claims per member we expect in 2014. Based on our claims data and the federal reinsurance parameters, we estimate that reinsurance will cover 12.5% of paid claims. This 12.5% decrement to medical costs is applied evenly across all plans as a constant multiplicative factor.

Additionally, we evaluated various scenarios to estimate whether the $10 billion dollar federal reinsurance pool would be sufficient to cover 12.5% of paid claims. Internal and external estimates for membership in the individual market and paid claims per member per month in the individual market were used to develop and estimate for the total number of paid claims. Our best estimate determined that the $10 billion pool would be sufficient to cover 12.5% of claims, so no further adjustments were made.

D. Non-Benefit Expenses and Profit and Risk

1. *Please discuss how the percentage loads were allocated by product or plan*

Please reference Section 10 of the Actuarial Memorandum for a breakdown of our retention components. Non-benefit expenses, profit and risk loads are allocated at the plan level. Per member per month expense components are added to our base claim costs then all percentage components are derived off of this base and therefore there is variation by plan as a percentage of premium. Whereas expenses that vary as a percent of premium have a consistent retention percentage by plan.

Below are two examples demonstrating the allocation for a bronze and a gold plan. The pmpm components for acquisition & recurring admin are consistent for both plans with the percentage components varying when shown as a percentage of premium at the plan level. Alternatively, the commissions, profit and premium tax are consistent by plan as a percentage of premium, but vary as a pmpm by plan. Please note that the fees are a combination of pmpm and percentage components therefore they will not match in either scenario unless broken out more granularly.

Plan ID	Medical Cost	Acquisition Admin.	Recurring Admin.	Commissions	Profit & Risk	Premium Tax	Fees	Final premium
99248TN0020001	$196	1.8%	3.9%	4.0%	2.5%	1.8%	7.1%	$249
99248TN0020007	$291	1.2%	2.7%	4.0%	2.5%	1.8%	6.5%	$358
99248TN0020001	$196	$4.47	$9.79	$9.94	$6.21	$4.35	$17.64	$249
99248TN0020007	$291	$4.47	$9.79	$14.31	$8.94	$6.26	$23.10	$358

E. Projected Loss Ratio

1. *Please reconcile the figures for incurred claims and earned premium shown in the demonstration of projected PPACA 2014 MLR with the corresponding 2014 projected figures shown in URRT worksheet 1, section III.*

CHLIC is projecting a PPACA 2014 MLR of 82.3%. As mentioned in our response to A.1., our claim and rate development does not exactly align to the process shown in Worksheet 1. As mentioned in the Actuarial Memorandum, the earned premium projection is developed from the PMPM on worksheet 2 multiplied by the projected member months on worksheet 1. As seen on worksheet 2, this premium PMPM does not exactly tie to worksheet 1, but is within a 2% corridor. Similarly, for the same reason our projected claim PMPM does not tie exactly to the projection on worksheet 1, but is within a 2% corridor.

Our projected earned premium and incurred claims are developed using the following data:

Projected Member Months per Worksheet 1 of URRT	30,951
Average Rate PMPM per Worksheet 2 of URRT	$293
Earned Premium per Projection	$9,056,732
Projected Member Months per Worksheet 1 of URRT	30,951
Average Incurred Claim PMPM	$268
Incurred Claims per Projection	$8,280,440

The projected claim PMPM used is developed by blending our projected paid claims by age, plan and area before the adjustment for reinsurance payments. Therefore the initial incurred loss ratio is 91.4%, but after making adjustments for reinsurance payments, the projected claims PMPM is lowered and the resulting projected loss ratio is 80%. After the additional adjustments that are permitted under PPACA, the projected loss ratio without adjustment for credibility is 82.3%.

F. Index Rate

1. *Please provide a description of the methodology used to adjust the index rate to arrive at each plan level rate based on the allowable adjustments outlined in 45CFR 156.80(d).*

As referenced in Section 12 of the Actuarial Memorandum, the projected index rate has been adjusted using the allowable modifiers in order to arrive at each plan level rate. Below we have outlined these modifiers and provided a description of the methodology used to adjust the index rate in order to arrive at the plan level rate.

- The AV of the plan – this adjustment is the actuarial value of the plan as determined by the actuarial value calculator as described in our unique plan design justification. The AV is multiplied by the index rate as the first step to get to a plan level specific rate for the average age represented by the index rate.
- The cost-sharing design of the plan – this adjustment is the result of differences in the experience underlying CHLIC's manual rate and the experience underlying the continuance tables in the AV calculator and expected utilization differences driven by the underlying cost share of the plan. The claims probability distribution (CPD) developed using the underlying experience of the manual rate is based on claims and enrollment data from Cigna's national group book of business. The continuance tables in the AV calculator are based on the default standard population developed by HHS using 2010 claims and enrollment from a national commercial database. This factor varies by plan and is multiplied by the by plan level rate from the previous step.
- The plan's provider network – this adjustment is the result of CHLIC's new provider network that is different from the network underlying the experience used in deriving the Manual Rate. This factor is multiplied by the plan level rate from the previous step.
- Administrative costs – this adjustment represents CHLIC's non-medical expenses (acquisition admin expenses, recurring admin expenses, commissions), profit load, and premium tax and fees which can vary either as a pmpm by plan or by a percentage of premium by plan. These administrative costs are incorporated as an adjustment to the previous step as described in the

response to objection D. Note, the exchange user fee has been applied consistently across all plans as a single multiplicative adjustment.

The relativities of these adjustments by plan can be seen in Section 14 of the Actuarial Memorandum which shows the derivation of the pricing AV or pricing relativities by plan. In addition to these modifiers, additional adjustments are made to arrive at the final premium for a single policyholder. These include adjustments for expected payments for reinsurance and the age, rating area, and tobacco usage status of a policyholder. In addition, for family policies, a maximum of 3 dependents under the age of 21 will be used to determine a rate.

Please contact Mitchell Pawlowski at 860.226.4565 or at Mitchell.Pawlowski@Cigna.com with any questions or concerns.

Thank you for your attention.

Sincerely,

Lauren Danziger

Lauren Danziger, FSA, MAAA
Actuarial Manager

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

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

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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.

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by

Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $[0-~~25~~6,~~0~~100] $[0-~~50~~12,~~0~~200]	**Out-of-Network Deductible** ~~[~~$[0-~~50~~12,~~0~~500]~~]~~ ~~[~~$[0-~~100~~25,000]~~]~~
Coinsurance ~~Primary Care Provider (PCP)~~ ~~Specialist~~ ~~Other Covered Services~~	~~[0-40]%~~ ~~[~~You and Your Family Members pay [0-~~5~~40]% of Charges after the Policy Deductible.~~]~~ ~~[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]~~	~~[0-50]%~~ ~~[~~You and Your Family Members pay [0-50]% after the Policy Deductible.~~]~~ ~~[You and Your Family Members pay [0-50]% after the Policy Deductible.]~~
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** ~~[~~$[0-~~30~~6,~~00~~350]~~] [Not Applicable]~~ ~~[~~$[0-~~60~~12,~~0~~700]~~] [Not Applicable]~~ ~~[~~The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.~~]~~	**Out-of-Network Out-of-Pocket Maximum** ~~[~~$[0-25,000~~unlimited]~~] ~~[Not Applicable]~~ ~~[~~$[0-50,000~~unlimited]~~] ~~[Not Applicable]~~ ~~[~~The following do not accumulate to the Out-of-Network Out of Pocket Maximum: ~~[Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential~~

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
		~~Health Benefits,] [and] [Mental Health] [and] [Substance Abuse charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][~~Penalties~~]~~ and Policy Maximums.~~]~~
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 information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance. **Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed ~~[~~a~~-~~] $~~[~~500~~-$1,000],~~ ~~[~~penalty~~]~~** for non-compliance. **You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed ~~[~~a~~]~~ $~~[5~~60~~-$500],~~ ~~[~~penalty~~]~~** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]%~~ [Deductible waived][Not Covered]~~
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits **Comprehensive Eye Exam and Refraction for Children** Limited to one exam per year **Eyeglasses and Lenses for Children**	~~[~~0~~-50~~%~~% per exam]~~ ~~[~~Deductible waived~~]~~ ~~[~~0~~-50~~%~~ per pair]~~ ~~[~~Deductible waived~~]~~	~~[~~You pay all but $30 per exam~~]~~ ~~[Not Covered]~~ ~~[Not Covered]~~

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
Frames Single Vision Lined Bifocal Lined Trifocal or Lenticular Limited to one pair per year **Contact Lenses for Children** Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	[0-50% per pair] [Deductible waived]	[You pay all but $30 per frame] [You pay all but $25 per pair] [You pay all but $35 per pair] [You pay all but $45 per pair] [Not Covered] [You pay all but $75 per pair] [You pay all but $225 per pair]
Physician Services **Office Visit** **Primary Care Physician (PCP)**	[$[0-2530] Copayment] per office visit; [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.][0%] [Visits [1-10]2 per Year: $[30-250] Copayment per office visit, Deductible waived] [; all visits after the first [1-10]2 per Year: [30-540]%] [visits [2-10]-[3-15] per Year: [50-100]%] [visits over [5-15] per Year: [50-100]%]	[0-50]% [Not Covered]
Specialist, (including consultant, referral and second opinion services)	[$[0-60] Copayment per office visit; Deductible waived][0%][Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%] [$[0-250] Copayment] [per office visit] [[0-50]%] [Deductible waived] [No charge after office visit copay if only	[[0-50]%] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.	~~x-ray and/or lab services are performed and billed.]~~ ~~[Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%]~~ ~~[visits [2-10]-[3-15] per Year: [0-50]%]~~ ~~[visits over [5-15] per Year: [0-50]%]~~	
Physician Services, continued		
Surgery in Physician's office	~~[~~[0-40]%~~]][included in Office Visit copayment] [Deductible waived]~~	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy	~~[~~[0-40]%~~] [included in outpatient facility copayment] [Deductible waived]~~	~~[~~[0-50]%~~][Not Covered]~~
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	[0-40]%~~ [Deductible waived]~~	~~[~~[0-50]%~~][Not Covered]~~
In-hospital visits	[0-40]%~~ [Deductible waived]~~	~~[~~[0-50]%~~][Not Covered]~~
Allergy testing and treatment/injections	~~[~~[0-40]%~~] [included in Office Visit copayment] [Deductible waived]~~	~~[~~[0-50]%~~][Not Covered]~~
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	~~[~~[0-~~5~~4~~0]%~~	[0-50]% ~~[Not Covered]~~
Hospital Services		
Inpatient Hospital Services Facility Charges	~~[$[500-5,000] Additional Deductible per admission, then][~~[0-~~5~~4~~0]%~~ ~~[$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient~~	~~[$[500-5,000] Additional Deductible per admission, then][~~[0-50]%~~]~~ ~~[Not Covered]~~

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
	~~copayments per Year]]~~	
Professional Charges	~~[$[500-5,000] Additional Deductible per admission, then]~~[0-~~5~~4~~0~~0]%~~]~~ ~~[Included in facility per-day copayment]~~	~~[$[500-5,000] Additional Deductible per admission, then]~~[[0-50]%~~]~~ ~~[Not Covered]~~
Emergency Admissions Facility Charges	~~[$[500-$1,5,000] Additional Deductible per admission, then]~~[0-~~5~~4~~0~~0%]~~%~~ ~~[$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]~~	~~In-Network benefit level until transferable to an Participating In-Network Hospital then [~~[0-50]%~~]~~~~[Not Covered]~~
Professional Charges	~~[$[500-5,000] Additional Deductible per admission, then]~~[[0-~~5~~4~~0~~0]%~~]~~ ~~[Included in facility per-day copayment]~~	~~[In-Network benefit level until transferable to an In-Network Hospital then [~~[0-50]%~~ [Not Covered]~~
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	~~[$[500-2,500] Additional Deductible per [service][visit][admission] then]~~[[0-~~5~~4~~0~~0]%~~]~~ ~~[$[500-2,000] Copayment per [service][visit][admission]]~~	~~[$[500-2,500] Additional Deductible per [service][visit][admission] then]~~[[0-50]%~~] [to a maximum payment of $[500-1,500] per [service][visit][admission]]~~ ~~[Not Covered]~~
Emergency Services		
Emergency Room	~~[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]]~~[[0-~~5~~4~~0~~0]%~~]]~~	In-network benefit level for an emergency medical condition, otherwise ~~[[$[50-500] [Access Fee, waived if admitted]per visit [then]]~~[[0-50]%~~]]~~
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	[0-~~5~~4~~0~~0]% ~~[~~for ~~[~~Ground ~~]~~[or ~~]~~Air ~~]~~[transport~~]~~.	In-network benefit level for an emergency medical condition, otherwise ~~[~~[0-50]%~~]~~ ~~[~~for ~~[[~~Ground ~~]~~[or ~~]~~[Air ~~]~~transport~~]~~.
Urgent Care	[$~~[~~2~~7~~5~~-250]~~ Copayment per visit; Deductible waived] ~~[then]~~ [[0~~-50]~~%]	In-network benefit level for an emergency medical condition, otherwise ~~[$[25-250] Copayment per visit] [then] [~~[0-50]%~~]~~

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	~~[~~[0-~~5~~40]%~~]~~ ~~[MRI:]~~ ~~[MRA:]~~ ~~[PET:]~~ ~~[CT Scan:]~~ ~~[Nuclear Medicine:]~~ ~~[$[100-1,000] Copayment per scan]~~	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	~~[$[0-250] Copayment] [~~[0-~~5~~40]%~~][Subject to PCP/specialist office visit benefit]~~ ~~[0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]~~	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Free-standing/Independent lab or x-ray facility	~~[~~[0-~~5~~40]%~~] [Deductible waived]~~ ~~[0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]~~	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Outpatient hospital lab or x-ray	~~[~~[0-~~5~~40]%~~]~~ ~~[0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent/ X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]~~	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	~~[$[0-250] Copayment] [PCP][or][specialist office visit benefit applies]~~ ~~[~~[0-~~5~~40]%~~] [All except [$10-$50] Per Insured Person, per visit.]~~	[0-50]% ~~[Not Covered]~~ ~~[All except [$10-$50] Per Insured Person, per visit.]~~

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined	[0-~~5~~40]% ~~[$[10-200] Copayment] [[PCP][or][specialist office visit benefit applies][per visit]~~ ~~[All except$[10-50] per [day] [visit].]~~	~~[~~[0-50]%~~][All except$[10-50] per visit]~~ ~~[Not Covered]~~
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-~~5~~40]%	~~[~~[0-50]%~~]~~ ~~[Not Covered]]~~
Habilitative Services Including Physical, Occupational, and Speech Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	~~[~~[0-~~5~~40]%~~] [$[0-250] Copayment]~~ ~~[[PCP][or][specialist office visit benefit applies][per visit]~~ ~~[All except $[10-50] Per Insured Person, per visit.]~~	~~[~~[0-50]%~~]~~ ~~[All except $[10-50] Per Insured Person, per visit.]~~ ~~[Not covered]~~
Womens' Contraceptive Services, Family Planning and Sterilization	~~[~~No charge, no Deductible~~]~~	~~[~~[0-50]%~~][Not Covered]~~
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	~~[~~[0-50]%~~]~~ ~~[Not covered]~~
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee Primary Care Physician (PCP) Specialist Physician	[$[0-30] Copayment per office visit; Deductible waived][0%][Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%] [$[0-60] Copayment per office visit; Deductible waived][0%][Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%] ~~[$[0-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are~~	~~[~~[0-50]%~~][Not Covered]~~ [0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prenatal services, Postnatal and Delivery (billed as "global" fee) Hospital Delivery charges Prenatal testing or treatment and postnatal visit or treatment billed separately from "global" fee Postnatal visit or treatment billed separately from "global" fee Primary Care Physician (PCP) Specialist Physician	performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [0-540]% [[$500-5000] Additional Deductible per admission, then][0-540]% [$[0-30] Copayment per office visit; Deductible waived][0%][Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%] [$[0-60] Copayment per office visit; Deductible waived][0%][Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%] [0-50]% [Deductible waived] [$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[[0-50]%][Not Covered] [[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered] [[0-50]%][Not Covered] [0-50]%[Not Covered]
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child under age 8.	[0-540]%	[[0-50]%] [Not Covered]

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	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-~~5~~40]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-~~5~~40]%	[0-~~1~~50]%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year, ~~[~~combined In- and Out-of-Network, ~~]~~for all facilities listed	~~[$[500-5000] Additional Deductible per admission, then] [~~[0-~~5~~40]%~~]~~ ~~[$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]~~	~~[$[500-5000] Additional Deductible per admission, then]~~ ~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	[0-~~5~~40]%	~~[~~[0-50]%~~]~~ ~~[Not Covered]~~
Durable Medical Equipment	[0-~~5~~40]%	~~[[0-50]%]~~ ~~[~~Not Covered~~]~~
Prosthetics	[0-~~5~~40]%	~~[~~[0-50]%~~][Not Covered]~~
Hospice Inpatient Outpatient	~~[~~[0-~~5~~40]%~~][Inpatient Hospital Services benefit applies]~~ ~~[~~[0-~~5~~40]%~~][$[25-250] Copayment per [day][visit] [Deductible waived]~~	~~[[$500-5000] Additional Deductible per admission, then]~~[0-50]%~~][Not Covered]~~ ~~[~~[0-50]%~~][Not Covered]~~
Dialysis Inpatient	Inpatient Hospital Services benefit applies	~~[[$500-5000] Additional Deductible per admission, then][[0-50]%]~~[Not Covered~~]~~

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	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Outpatient	[$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-540]%] [$[500-2,000] Copayment per [service][visit][admission]]	[[0-50]%] [Not Covered]
Autism Spectrum Disorders For Insured Persons under age 12 only Diagnosis of Autism Spectrum Disorder Office Visit Diagnostic testing Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	[PCP or Specialist Office Visit benefit applies][$[0-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-540]%] [0-50]% Copay or Coinsurance applies for specific benefit provided	[[0-50]%][Not Covered] [[0-50]%][Not Covered] [[0-50]%][Not Covered]
Mental, Emotional or Functional Nervous Disorders Inpatient Outpatient	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-540]%] [$[0-250] [copay] [PCP][specialist Office Visit benefit applies] [per visit] [[0-50]%] [Deductible waived]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [Not Covered] [[0-50]%] [Not Covered]]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Substance Abuse		
Inpatient Rehabilitation	[$[500-5,000] Additional Deductible per admission, then] [[0-540]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	[[$[500-5,000] Additional Deductible per admission, then] [0-50]%] [Not Covered]
Outpatient	[$[0-250] [specialist Office Visit benefit applies] [per visit][0-40]%	[[0-50]%] [Not Covered]]
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)		
Cigna LIFESOURCE Transplant Network® Facility]	[$[500-5,000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [0%-50]%	NOT APPLICABLE
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		NOT APPLICABLE
Other Cigna Network Facility	[$[500-5,000] Additional Deductible per admission, then][0-50]%] [$[250-2,000] Copayment per inpatient day [Limit of [3-10]days of inpatient copayments per year]][0-540%]]	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	[$[500-5,000] Additional Deductible per admission, then] [0-50]%][Not Covered]

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	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
		~~[Subject to the following limits per transplant:~~ ~~Heart - $150,000~~ ~~Liver - $230,000~~ ~~Bone Marrow -$130,000~~ ~~Heart/Lung - $185,000~~ ~~Lung - $185,000~~ ~~Pancreas - $50,000~~ ~~Kidney - $80,000~~ ~~Kidney/Pancreas – $80,000]~~
Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-~~5~~40]%	~~[~~[0-50]%~~][Not Covered]]~~

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. **In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule.** **Covered in-network only**		
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum [30-~~90]~~-day supply)** **~~[(Maximum [31-100]-day supply) for Maintenance Medications]~~**	
Tier 1: Retail Preferred Generic	[$~~[2-10]~~4 Copayment, Deductible waived][0%] per Prescription or refill~~]~~ ~~[and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]~~ ~~[Deductible waived]~~	~~[[50]% per Prescription or refill][~~Not Covered~~]~~
Tier 2: Retail Non-Preferred Generic	[$[10-20] Copayment, Deductible waived][[0-40]%] ~~Copay~~ per Prescription or refill~~]~~ ~~[and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]~~ ~~[Deductible waived]~~	~~[[50]% per Prescription or refill][~~Not Covered~~]~~
Tier 3: Retail Preferred Brand	[$[420-60] Copayment, Deductible waived][[0-40]%] per Prescription or refill ~~]~~ ~~[and $[120-150] Copay per Maintenance Drug Prescription or refill]~~ ~~[~~plus the difference between the cost of the brand name medication and the generic equivalent~~][[0-50]%]~~ ~~[Deductible waived]~~	~~[[50]% per Prescription or refill][~~Not Covered~~]~~
Tier 4: Retail Non-Preferred Brand	[0-50]% ~~plus a $[60-80] Copay~~ per Prescription or refill ~~[and [0-50]% plus a $[150-200] Copay per Prescription or refill]~~ ~~[~~ plus the difference between the cost of the brand name medication and the generic equivalent~~]~~	~~[[50]% per Prescription or refill][~~Not Covered~~]~~

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	[[0-530]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You pay 100% of Cigna's discounted cost of the drug]] [plus the difference between the cost of the brand name medication and the generic equivalent]	[[50]% per Prescription or refill]][Not Covered]
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	[[50]% per Prescription or refill]][Not Covered]
Cigna Tel-Drug Mail Order Pharmacy Drug Program	**(Maximum [90-100]-day supply)** **[(Maximum [30-100]-day supply for Specialty Medications)]**	
Tier 1: Mail Order Preferred Generic	[$[2-10] Copayment, Deductible waived][0%] per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill]][[0-50]%]	[Not available]
Tier 2: Mail Order Non-Preferred Generic	[$[1025-50] Copayment, Deductible waived][[0-40]%] per Prescription or refill]] [and $[20-50] Copay per Maintenance Drug Prescription or refill]][[0-50]%]	[Not available]
Tier 3: Mail Order Preferred Brand	[$[450-6150] Copayment, Deductible waived][[0-40]%] per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [plus the difference between the cost of the brand name medication and the generic equivalent]][[0-50]%]	[Not available]
Tier 4: Mail Order Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill plus the difference between the cost of the	[Not available]

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
	brand name medication and the generic equivalent ~~[and [0-50]% plus a $[150-200] Copay per Prescription or refill]~~	
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	[0-~~5~~30]% per Prescription or refill ~~[and $[120-150] Copay per Maintenance Drug Prescription or refill]~~ ~~[and [0-50]% per Maintenance Drug Prescription or refill]~~	~~[~~Not available~~]~~
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	~~[~~Not available~~]~~

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.

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

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

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.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Copayment/Copay is 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 and Reconstructive 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. 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”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of deductibles may apply to this Policy and all are defined in this section. See the definitions for Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

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

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational 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 its is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- it is the subject of an on-going clinical trial, except as provided in the "Clinical Trials" section of this plan.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

~~The~~ **Family Out-of-Network Out-of-Pocket Maximum:** Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- ~~3.~~ it maintains diagnostic laboratory and x-ray facilities;
- ~~4)~~ it has equipment for emergency care;
- ~~5.~~ it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Habilitative Services are those services that are

~~1.~~(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,

~~2.~~(ii) are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and

~~3.~~(iii) are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Out-of-Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification.

Injury means an accidental bodily injury.

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

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-

Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons;or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins on January 1st of each year. Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Service Area is any place that is within the counties and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, Lifetime, per visit, per day, or per event maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled “How The Policy Works”.

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached 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 or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna in writing within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month in the Year following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next

Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on the Federally Facilitated Marketplace ("on marketplace" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- 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.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on the Federally Facilitated Marketplace ("off-marketplace plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or

agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or

- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- [The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or

The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.
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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- When the Insured no longer lives in the Service Area.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the

appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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.

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

- If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.

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 Maximums;
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

In addition, the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;
  - Not for exercise; and
  - And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic ,and Speech Therapy)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:

Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

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

Benefits for 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 are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional or Functional Nervous Disorders and Substance Abuse

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, ,or substance abuse must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, ,or substance abuse and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram.
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

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

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 if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Hearing Aids

Hearing aids for children to age 18 are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses for Insured Persons under age 12 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:

   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

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

3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

   a) self care and feeding,

   b) pragmatic, receptive, and expressive language,

   c) cognitive functioning,

   d) applied behavior analysis, intervention, and modification,

9. e) motor planning, and

10. f) sensory processing.

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are not covered.
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.

- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV)**,** for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

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

For clinical trials, routine patient costs do not include—

1. the investigational item, device, or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. costs for the management of research relating to the clinical trial or study;
4. any portion of the clinical trial or study that is paid for by a government or a bio-technical, pharmaceutical, or medical industry;
5. coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;

6. extraneous expenses related to participation in the clinical trial; or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

Treatment of Diabetes

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

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

Home Health Care

To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of

Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

- 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.
- 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.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** for Insured Person's 19 and over, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems.
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- 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.
- Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.

- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Plan Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment or Coinsurance will apply to each Prescription Drug.

In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copayment or Coinsurance shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  - 1. a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  - 2. a. it has been otherwise approved by the FDA; and
  - 3. b. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- 1. drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- 1. drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- 2. any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- 1. a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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;
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Drugs that are not on the Prescription Drug List;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for Specialty Medications and Self-Administered Injectable Drugs, at a home delivery Pharmacy unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.

Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.

Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that You or Your Physician requests a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copayment or Coinsurance shown in the Schedule.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior

Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses per year, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

Coordination Of Benefits

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.
- If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person’s medical condition.

Cigna’s Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna’s decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner’s office. The Commissioner may make a different determination regarding the Insured Person’s eligibility for an expedited external review. The Commissioner’s office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance

500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: 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 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 intentional, 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not

receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
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, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

Any cancellation shall be without prejudice for any claim for Covered Expense 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 this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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.

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

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

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

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

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

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating

Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of

why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

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

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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.

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $[0-6,100] $[0-12,200]	**Out-of-Network Deductible** $[0-12,500] $[0-25,000]
Coinsurance	You and Your Family Members pay [0-40]% of Charges after the Policy Deductible.	You and Your Family Members pay [0-50]% after the Policy Deductible.
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** $[0-6,350] $[0-12,700] The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.	**Out-of-Network Out-of-Pocket Maximum** $[0-25,000] $[0-50,000] The following do not accumulate to the Out-of-Network Out of Pocket Maximum: Penalties and Policy Maximums.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prior Authorization Program		
Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed a] $500 penalty** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed a $60 penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]%
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% Deductible waived	You pay all but $30 per exam
Eyeglasses and Lenses for Children	0% Deductible waived	
Frames		You pay all but $30 per frame
Single Vision		You pay all but $25 per pair
Lined Bifocal		You pay all but $35 per pair
Lined Trifocal or Lenticular		You pay all but $45 per pair
Limited to one pair per year		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Contact Lenses for Children Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% Deductible waived	 You pay all but $75 per pair You pay all but $225 per pair
Physician Services		
Office Visit		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist, (including consultant, referral and second opinion services)	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Physician Services, continued		
Surgery in Physician's office	[0-40]%	[0-50]%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy	[0-40]%	[0-50]%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	[0-40]%	[0-50]%
In-hospital visits	[0-40]%	[0-50]%
Allergy testing and treatment/injections	[0-40]%	[0-50]%
Hearing Aids for children ~~through age 18~~ **Maximum one hearing aid per ear every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	[0-40]%	[0-50]%
Hospital Services		
Inpatient Hospital Services		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Emergency Admissions		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Emergency Services		
Emergency Room	[0-40]%	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	[0-40]% for Ground or Air transport.	In-network benefit level for an emergency medical condition, otherwise [0-50]% for Ground or Air transport.
Urgent Care	[$75 Copayment per visit; Deductible waived] [0%]	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[0-40]%	[0-50]%
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	[0-40]%	[0-50]%
Free-standing/Independent lab or x-ray facility	[0-40]%	[0-50]%
Outpatient hospital lab or x-ray	[0-40]%	[0-50]%
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-40]%	[0-50]%
Habilitative Services Including Physical, Occupational, and Speech Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Womens' Contraceptive Services, Family Planning and Sterilization	No charge, no Deductible	[0-50]%
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[0-50]%
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-40]%	[0-50]%
Hospital Delivery charges	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prenatal testing or treatment and postnatal visit or treatment billed separately from "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child ~~under age 8~~.	[0-40]%	[0-50]%
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-40]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-40]%	[0-50]%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year, combined In- and Out-of-Network, for all facilities listed	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	[0-40]%	[0-50]%
Durable Medical Equipment	[0-40]%	Not Covered
Prosthetics	[0-40]%	[0-50]%
Hospice		
Inpatient	[0-40]%	[0-50]%
Outpatient	[0-40]%	[0-50]%
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	Not Covered
Outpatient	[0-40]%	Not Covered
Autism Spectrum Disorders ~~For Insured Persons under age 12 only~~ (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	[0-40]%	[0-50]%
Mental, Emotional or Functional Nervous Disorders		
Inpatient	[0-40]%	[0-50]%
Outpatient	[0-50]%	[0-50]%
Substance Abuse		
Inpatient Rehabilitation	[0-40]%	[0-50]%
Outpatient	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility]**	0%	NOT APPLICABLE
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		
Other Cigna Network Facility	[0-40%]	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-40]%	[0-50]%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. **In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule.** **Covered in-network only**		
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum 30-day supply)**	
Tier 1: Retail Preferred Generic	[$4 Copayment, Deductible waived] [0%] per Prescription or refill	Not Covered
Tier 2: Retail Non-Preferred Generic	[$[10-20] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not Covered
Tier 3: Retail Preferred Brand	[$[20-60] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 4: Retail Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 5: Specialty generic and brand name medications		Not Covered

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
that meet criteria of specialty drugs	[0-30]% per Prescription or refill	
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not Covered
Cigna Tel-Drug Mail Order Pharmacy Drug Program	**(Maximum 90-day supply)** **(Maximum 30-day supply for Specialty Medications)**	
Tier 1: Mail Order Preferred Generic	[$10 Copayment, Deductible waived] [0%] per Prescription or refill	Not available
Tier 2: Mail Order Non-Preferred Generic	[$[25-50] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not available
Tier 3: Mail Order Preferred Brand	[$[50-150] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available
Tier 4: Mail Order Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	[0-30]% per Prescription or refill	Not available
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not available

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.

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

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

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.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Copayment/Copay is 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 and Reconstructive 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. 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”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of deductibles may apply to this Policy and all are defined in this section. See the definitions for Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

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

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational 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 its is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- it is the subject of an on-going clinical trial, except as provided in the “Clinical Trials” section of this plan.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Out-of-Pocket Maximum: Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Free-Standing Outpatient Surgical Facility
The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Out-of-Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification.

Injury means an accidental bodily injury.

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

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons;or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins on January 1st of each year. Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Service Area is any place that is within the counties and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, Lifetime, per visit, per day, or per event maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled “How The Policy Works”.

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached 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 or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna in writing within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month in the Year following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on the Federally Facilitated Marketplace ("on marketplace" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- 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.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on the Federally Facilitated Marketplace ("off-marketplace plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or

- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

~~An individual **will not be entitled to enroll** as an Insured Person if:~~

- ~~[The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*~~
- ~~The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or~~

~~The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.~~

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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- When the Insured no longer lives in the Service Area.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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.

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

- If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.

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 Maximums;
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.

- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

In addition, the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;

- Not for exercise; and
- And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic, and Speech Therapy)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:
Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

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

Benefits for 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 are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional or Functional Nervous Disorders and Substance Abuse

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, ,or substance abuse must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, ,or substance abuse and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child ~~8 years of age or younger~~ when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram.
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.

- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

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

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 if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Hearing Aids

Hearing aids for children ~~to age 18~~ are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses ~~for Insured Persons under age 12 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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

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

3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

a) self care and feeding,

b) pragmatic, receptive, and expressive language,

c) cognitive functioning,

d) applied behavior analysis, intervention, and modification,

e) motor planning, and

f) sensory processing.

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are not covered.
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.

- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV), for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

- Services typically provided absent a clinical trial.
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service.

- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service.
- Services required for reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs do not include—

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

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

Treatment of Diabetes

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

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

Home Health Care

To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

- 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.
- 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.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** ~~for Insured Person's 19 and over~~, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems, except as specifically stated in this policy.
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- 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.
- Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.

- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Plan Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment or Coinsurance will apply to each Prescription Drug.

In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copayment or Coinsurance shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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;
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Drugs that are not on the Prescription Drug List;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for Specialty Medications and Self-Administered Injectable Drugs, at a home delivery Pharmacy unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.

Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.

Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that You or Your Physician requests a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copayment or Coinsurance shown in the Schedule.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior

Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses per year, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

Coordination Of Benefits

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.
- If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and

- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: 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 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 intentional, 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one

full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
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, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

Any cancellation shall be without prejudice for any claim for Covered Expense 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 this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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.

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

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

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

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

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

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating

Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of

why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 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.

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/12/2013	Replaced 07/29/2013	Form	INDTNCH042013	07/25/2013	IND_TN_CH_Policy_071113_Clean.pdf (Superceded)
06/13/2013	Replaced 07/29/2013	Form	INDTNCH042013	07/12/2013	IND_TN_CH_Policy_062013_Clean.pdf (Superceded)
05/15/2013	Replaced 07/29/2013	Rate	Rate pages	06/13/2013	TN.RateTables.v2.2.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Form	INDTNCH042013	06/13/2013	IND_TN_CH_Policy_042013_Clean.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Form	INDTNCHSPEC042013	06/13/2013	IND_TN_CH_Spec_042013_Clean.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Rate	Rate pages	05/15/2013	TN.RateTables.v2.2.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Supporting Document	AVP inputs	06/13/2013	TN.AVCInputs.04.22.2013.99248.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Supporting Document	Business Rules	05/15/2013	TN.RatingBusinessRules.v1.5.pdf
04/25/2013	Replaced 07/29/2013	Supporting Document	Actuarial Memorandum and Certifications	06/13/2013	TN.Part3ActuarialMemorandum.04.22.2013.99248.pdf (Superceded)
04/25/2013	Replaced 07/29/2013	Supporting Document	Unified Rate Review Template	06/13/2013	TN.UnifiedRateReviewSubmission.v1.6.pdf (Superceded)

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

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

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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.

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $[0-6,100] $[0-12,200]	**Out-of-Network Deductible** $[0-12,500] $[0-25,000]
Coinsurance	You and Your Family Members pay [0-40]% of Charges after the Policy Deductible.	You and Your Family Members pay [0-50]% after the Policy Deductible.
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** $[0-6,350] $[0-12,700] The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.	**Out-of-Network Out-of-Pocket Maximum** $[0-25,000] $[0-50,000] The following do not accumulate to the Out-of-Network Out of Pocket Maximum: Penalties and Policy Maximums.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prior Authorization Program		
Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed a] $500 penalty** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed a $60 penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]%
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% Deductible waived	You pay all but $30 per exam
Eyeglasses and Lenses for Children	0% Deductible waived	
Frames		You pay all but $30 per frame
Single Vision		You pay all but $25 per pair
Lined Bifocal		You pay all but $35 per pair
Lined Trifocal or Lenticular		You pay all but $45 per pair
Limited to one pair per year		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Contact Lenses for Children Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	0% Deductible waived	 You pay all but $75 per pair You pay all but $225 per pair
Physician Services		
Office Visit		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist, (including consultant, referral and second opinion services)	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Physician Services, continued		
Surgery in Physician's office	[0-40]%	[0-50]%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy	[0-40]%	[0-50]%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	[0-40]%	[0-50]%
In-hospital visits	[0-40]%	[0-50]%
Allergy testing and treatment/injections	[0-40]%	[0-50]%
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	[0-40]%	[0-50]%
Hospital Services		
Inpatient Hospital Services		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Emergency Admissions		
Facility Charges	[0-40]%	[0-50]%
Professional Charges	[0-40]%	[0-50]%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Emergency Services		
Emergency Room	[0-40]%	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	[0-40]% for Ground or Air transport.	In-network benefit level for an emergency medical condition, otherwise [0-50]% for Ground or Air transport.
Urgent Care	[$75 Copayment per visit; Deductible waived] [0%]	In-network benefit level for an emergency medical condition, otherwise [0-50]%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[0-40]%	[0-50]%
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	[0-40]%	[0-50]%
Free-standing/Independent lab or x-ray facility	[0-40]%	[0-50]%
Outpatient hospital lab or x-ray	[0-40]%	[0-50]%
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-40]%	[0-50]%
Habilitative Services Including Physical, Occupational, and Speech Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[0-40]%	[0-50]%
Womens' Contraceptive Services, Family Planning and Sterilization	No charge, no Deductible	[0-50]%
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[0-50]%
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copayment per office visit, Deductible waived; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-40]%	[0-50]%
Hospital Delivery charges	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prenatal testing or treatment and postnatal visit or treatment billed separately from "global" fee		
Primary Care Physician (PCP)	[$[0-30] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $30 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Specialist Physician	[$[0-60] Copayment per office visit; Deductible waived] [0%] [Visits 1-2 per Year: $60 Copay; all visits after the first 2 per Year: [30-40]%]	[0-50]%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child under age 8.	[0-40]%	[0-50]%
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-40]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-40]%	[0-50]%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year, combined In- and Out-of-Network, for all facilities listed	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	[0-40]%	[0-50]%
Durable Medical Equipment	[0-40]%	Not Covered
Prosthetics	[0-40]%	[0-50]%
Hospice		
Inpatient	[0-40]%	[0-50]%
Outpatient	[0-40]%	[0-50]%
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	Not Covered
Outpatient	[0-40]%	Not Covered
Autism Spectrum Disorders For Insured Persons under age 12 only (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	[0-40]%	[0-50]%
Mental, Emotional or Functional Nervous Disorders		
Inpatient	[0-40]%	[0-50]%
Outpatient	[0-50]%	[0-50]%
Substance Abuse		
Inpatient Rehabilitation	[0-40]%	[0-50]%
Outpatient	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility]**	0%	NOT APPLICABLE
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		
Other Cigna Network Facility	[0-40%]	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-40]%	[0-50]%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. **In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule.** **Covered in-network only**		
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum 30-day supply)**	
Tier 1: Retail Preferred Generic	[$4 Copayment, Deductible waived] [0%] per Prescription or refill	Not Covered
Tier 2: Retail Non-Preferred Generic	[$[10-20] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not Covered
Tier 3: Retail Preferred Brand	[$[20-60] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 4: Retail Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not Covered
Tier 5: Specialty generic and brand name medications		Not Covered

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
that meet criteria of specialty drugs	[0-30]% per Prescription or refill	
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not Covered
Cigna Tel-Drug Mail Order Pharmacy Drug Program	**(Maximum 90-day supply)** **(Maximum 30-day supply for Specialty Medications)**	
Tier 1: Mail Order Preferred Generic	[$10 Copayment, Deductible waived] [0%] per Prescription or refill	Not available
Tier 2: Mail Order Non-Preferred Generic	[$[25-50] Copayment, Deductible waived] [[0-40]%] per Prescription or refill	Not available
Tier 3: Mail Order Preferred Brand	[$[50-150] Copayment, Deductible waived] [[0-40]%] per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available
Tier 4: Mail Order Non-Preferred Brand	[0-50]% per Prescription or refill plus the difference between the cost of the brand name medication and the generic equivalent	Not available

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs	[0-30]% per Prescription or refill	Not available
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	Not available

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.

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

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

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.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Copayment/Copay is 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 and Reconstructive 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. 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”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of deductibles may apply to this Policy and all are defined in this section. See the definitions for Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

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

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational 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 its is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- it is the subject of an on-going clinical trial, except as provided in the “Clinical Trials” section of this plan.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Out-of-Pocket Maximum: Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Free-Standing Outpatient Surgical Facility
The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Copayments, Deductibles and Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Out-of-Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. It includes Deductibles and Coinsurance for medical services incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification.

Injury means an accidental bodily injury.

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

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons;or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins on January 1st of each year. Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Service Area is any place that is within the counties and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, Lifetime, per visit, per day, or per event maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled “How The Policy Works”.

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached 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 or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna in writing within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month in the Year following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on the Federally Facilitated Marketplace ("on marketplace" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- 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.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on the Federally Facilitated Marketplace ("off-marketplace plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or

- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- [The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or

The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.
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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- When the Insured no longer lives in the Service Area.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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.

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

- If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.

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 Maximums;
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.

- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

In addition, the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;

- Not for exercise; and
- And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic, and Speech Therapy)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:
Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

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

Benefits for 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 are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional or Functional Nervous Disorders and Substance Abuse

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, ,or substance abuse must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, ,or substance abuse and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram.
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.

- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

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

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 if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Hearing Aids

Hearing aids for children to age 18 are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses for Insured Persons under age 12 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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

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

3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

a) self care and feeding,

b) pragmatic, receptive, and expressive language,

c) cognitive functioning,

d) applied behavior analysis, intervention, and modification,

e) motor planning, and

f) sensory processing.

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are not covered.
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.

- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV), for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

- Services typically provided absent a clinical trial.
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service.

- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service.
- Services required for reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs do not include—

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

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

Treatment of Diabetes

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

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

Home Health Care

To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

- 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.
- 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.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** for Insured Person's 19 and over, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems.
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- 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.
- Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.

- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Plan Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment or Coinsurance will apply to each Prescription Drug.

In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copayment or Coinsurance shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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;
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Drugs that are not on the Prescription Drug List;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for Specialty Medications and Self-Administered Injectable Drugs, at a home delivery Pharmacy unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.

Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.

Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that You or Your Physician requests a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copayment or Coinsurance shown in the Schedule.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior

Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses per year, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

Coordination Of Benefits

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.
- If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and

- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: 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 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 intentional, 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one

full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
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, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

Any cancellation shall be without prejudice for any claim for Covered Expense 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 this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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.

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

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

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

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

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

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating

Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of

why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

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

Cigna also reserves the right to change the premium on 30 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.

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
Tennessee [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. Eastern time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

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

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

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

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

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

If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider.

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

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

Prior Authorization For Inpatient Services

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

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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.

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

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

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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

Retrospective Review

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

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by

Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family	**In-Network Deductible** $[0-25,000] $[0-50,000]	**Out-of-Network Deductible** [$[0-50,000]] [$[0-100,000]]
Coinsurance Primary Care Provider (PCP) Specialist Other Covered Services	[0-40]% [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.] [You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[0-50]% [You and Your Family Members pay [0-50]% after the Policy Deductible.] [You and Your Family Members pay [0-50]% after the Policy Deductible.]
Out-of-Pocket Maximum Individual Family	**In-Network Out-of-Pocket Maximum** [$[0-30,000]] [Not Applicable] [$[0- 60,000]] [Not Applicable] [The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.]	**Out-of-Network Out-of-Pocket Maximum** [$[0-unlimited]] [Not Applicable] [$[0-unlimited]] [Not Applicable] [The following do not accumulate to the Out-of-Network Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential Health Benefits,] [and] [Mental Health] [and] [Substance Abuse

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
		charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][Penalties] and Policy Maximums.]
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 information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance. **Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed [a] $[500-$1,000], [penalty]** for non-compliance. **You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed [a] $[50-$500], [penalty]** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]% [Deductible waived][Not Covered]
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than 19 years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits **Comprehensive Eye Exam and Refraction for Children** Limited to one exam per year **Eyeglasses and Lenses for Children** Frames	[0-50%% per exam] [Deductible waived] [0-50% per pair] [Deductible waived]	[You pay all but $30 per exam] [Not Covered] [Not Covered] [You pay all but $30 per frame]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Single Vision Lined Bifocal Lined Trifocal or Lenticular Limited to one pair per year **Contact Lenses for Children** Elective Therapeutic Limited to one pair per year **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	[0-50% per pair] [Deductible waived]	[You pay all but $25 per pair] [You pay all but $35 per pair] [You pay all but $45 per pair] [Not Covered] [You pay all but $75 per pair] [You pay all but $225 per pair]
Physician Services **Office Visit** **Primary Care Physician (PCP)**	[$[0-250] Copayment] per office visit; [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250] Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [50-100]%] [visits over [5-15] per Year: [50-100]%]	[0-50]% [Not Covered]
Specialist, (including consultant, referral and second opinion services)	[$[0-250] Copayment] [per office visit] [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%]	[[0-50]%] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Note: if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed as a specialist, You or Your Family Member will pay the specialist Copayment.	[visits over [5-15] per Year: [0-50]%]	
Physician Services, continued		
Surgery in Physician's office	[[0-40]%]][included in Office Visit copayment] [Deductible waived]	[[0-50]%] [Not Covered]
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, radiation therapy	[[0-40]%] [included in outpatient facility copayment] [Deductible waived]	[[0-50]%][Not Covered]
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	[0-40]% [Deductible waived]	[[0-50]%][Not Covered]
In-hospital visits	[0-40]% [Deductible waived]	[[0-50]%][Not Covered]
Allergy testing and treatment/injections	[[0-40]%] [included in Office Visit copayment] [Deductible waived]	[[0-50]%][Not Covered]
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	[[0-50]%]	[0-50]% [Not Covered]
Hospital Services		
Inpatient Hospital Services Facility Charges	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Professional Charges	[$[500-5,000] Additional Deductible per admission, then][0-50]%] [Included in facility per-day copayment]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Not Covered]
Emergency Admissions Facility Charges	[$[500-$1,5,000] Additional Deductible per admission, then][0-50%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	In-Network benefit level until transferable to an Participating In-Network Hospital then [[0-50]%][Not Covered]
Professional Charges	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment]	[In-Network benefit level until transferable to an In-Network Hospital then [[0-50]% [Not Covered]
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital Facilities	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[0-50]%] [to a maximum payment of $[500-1,500] per [service][visit][admission]] [Not Covered]
Emergency Services		
Emergency Room	[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]][[0-50]%]]	In-network benefit level for an emergency medical condition, otherwise [[$[50-500] [Access Fee, waived if admitted]per visit [then]][[0-50]%]]
Ambulance Emergency transportation to the nearest facility capable of handling the emergency only.	[0-50]%[for [Ground][or]Air][transport].	In-network benefit level for an emergency medical condition, otherwise [[0-50]%] [for [[Ground][or][Air]transport].
Urgent Care	[$[25-250] Copayment per visit] [then] [[0-50]%]	In-network benefit level for an emergency medical condition, otherwise [$[25-250] Copayment per visit] [then] [[0-50]%]
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[[0-50]%] [MRI:] [MRA:] [PET:]	[[0-50]%] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
	[CT Scan:] [Nuclear Medicine:] [$[100-1,000] Copayment per scan]	
All Other Laboratory and Radiology Services Facility and interpretation charges		
Physician's Office	[$[0-250] Copayment] [[0-50]%][Subject to PCP/specialist office visit benefit] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]
Free-standing/Independent lab or x-ray facility	[[0-50]%] [Deductible waived] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]
Outpatient hospital lab or x-ray	[[0-50]%] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent/ X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]
Short-Term Rehabilitative Services Physical, Occupational, Speech, and Chiropractic Therapy Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[$[0-250] Copayment] [PCP][or][specialist office visit benefit applies] [[0-50]%] [All except [$10-$50] Per Insured Person, per visit.]	[0-50]% [Not Covered] [All except [$10-$50] Per Insured Person, per visit.]
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Insured Person, per calendar year, per	[0-50]% [$[10-200] Copayment] [[PCP][or][specialist office visit benefit	[[0-50]%][All except$[10-50] per visit] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
therapy, In- and Out-of-Network combined	applies][per visit] [All except$[10-50] per [day] [visit].]	
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-50]%	[[0-50]%] [Not Covered]]
Habilitative Services Including **Physical, Occupational, and Speech Therapy** Maximum of 20 visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined. **Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders.	[[0-50]%] [$[0-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per visit.]	[[0-50]%] [All except $[10-50] Per Insured Person, per visit.] [Not covered]
Womens' Contraceptive Services, Family Planning and Sterilization	[No charge, no Deductible]	[[0-50]%][Not Covered]
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[[0-50]%] [Not covered]
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee Prenatal services, Postnatal and Delivery (billed as "global" fee) Hospital Delivery charges	[$[0-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [0-50]% [[$500-5000] Additional Deductible per admission, then][0-50]% [0-50]% [Deductible waived]	[[0-50]%][Not Covered] [[0-50]%][Not Covered] [[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered] [[0-50]%][Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Prenatal testing or treatment billed separately from "global" fee Postnatal visit or treatment billed separately from "global" fee	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[Not Covered]
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child under age 8.	[0-50]%	[[0-50]%] [Not Covered]
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-50]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-50]%	[0-15]%
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Insured Person per calendar year [combined In- and Out-of-Network]for all facilities listed	[$[500-5000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]	[$[500-5000] Additional Deductible per admission, then] [[0-50]%] [Not Covered]
Home Health Services Maximum 60 visits per Insured Person, per calendar year. Maximum 16 hours per day Maximum 8 visits per day	[0-50]%	[[0-50]%] [Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
Durable Medical Equipment	[0-50]%	[[0-50]%] [Not Covered]
Prosthetics	[0-50]%	[[0-50]%][Not Covered]
Hospice		
Inpatient	[[0-50]%][Inpatient Hospital Services benefit applies]	[[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered]
Outpatient	[[0-50]%][$[25-250] Copayment per [day][visit] [Deductible waived]	[[0-50]%][Not Covered]
Dialysis		
Inpatient	Inpatient Hospital Services benefit applies	[[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered]
Outpatient	[$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[[0-50]%] [Not Covered]
Autism Spectrum Disorders For Insured Persons under age 12 only		
Diagnosis of Autism Spectrum Disorder		
Office Visit	[PCP or Specialist Office Visit benefit applies][$[0-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[[0-50]%][Not Covered]
Diagnostic testing		
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits What	[0-50]%	[[0-50]%][Not Covered]

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
the Policy Pays For" section for specific information about what services are covered)	Copay or Coinsurance applies for specific benefit provided	[[0-50]%][Not Covered]
Mental, Emotional or Functional Nervous Disorders Inpatient Outpatient	 [$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-50]%] [$[0-250] [copay] [PCP][specialist Office Visit benefit applies] [per visit] [[0-50]%] [Deductible waived]	 [$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [Not Covered] [[0-50]%] [Not Covered]]
Substance Abuse Inpatient Rehabilitation Outpatient	 [$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [$[0-250] [specialist Office Visit benefit applies] [per visit]	 [[$[500-5,000] Additional Deductible per admission, then] [0-50%] [Not Covered] [[0-50]%] [Not Covered]]
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility]** **Travel Benefit,** (Only available	 [$[500-5,000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [0%-50]%	 NOT APPLICABLE NOT APPLICABLE

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY	
through Cigna Lifesource Transplant Network ® Facility) Travel benefit Lifetime maximum payment of $10,000		
Other Cigna Network Facility	[$[500-5,000] Additional Deductible per admission, then][0-50]%] [$[250-2,000] Copayment per inpatient day [Limit of [3-10]days of inpatient copayments per year]][0-50%]]	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	[$[500-5,000] Additional Deductible per admission, then] [0-50]%][Not Covered] [Subject to the following limits per transplant: Heart - $150,000 Liver - $230,000 Bone Marrow -$130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas – $80,000]
Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-50]%	[[0-50]%][Not Covered]]

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution. **In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule.** **Covered in-network only**		
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum [30-90]-day supply)** **[(Maximum [31-100]-day supply) for Maintenance Medications]**	
Tier 1: Retail Preferred Generic	[$[2-10] Copay per Prescription or refill] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%] [Deductible waived]	[[50]% per Prescription or refill][Not Covered]
Tier 2: Retail Non-Preferred Generic	[$[10-20] Copay per Prescription or refill] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%] [Deductible waived]	[[50]% per Prescription or refill][Not Covered]
Tier 3: Retail Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%] [Deductible waived]	[[50]% per Prescription or refill][Not Covered]
Tier 4: Retail Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent]	[[50]% per Prescription or refill][Not Covered]
Tier 5: Specialty generic and brand name medications	[[0-50]% per Prescription or refill [and $[120-150] Copay per	[[50]% per Prescription or refill][Not Covered]

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
that meet criteria of specialty drugs	Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You pay 100% of Cigna's discounted cost of the drug]] [plus the difference between the cost of the brand name medication and the generic equivalent]	
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	[[50]% per Prescription or refill][Not Covered]
Cigna Tel-Drug Mail Order Pharmacy Drug Program	**Maximum [90-100]-day supply)** **[Maximum [30-100]-day supply for Specialty Medications]**	
Tier 1: Mail Order Preferred Generic	[$[2-10] Copay per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 2: Mail Order Non-Preferred Generic	[$[10-50] Copay per Prescription or refill]] [and $[20-50] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 3: Mail Order Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[Not available]
Tier 4: Mail Order Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[Not available]
Tier 5: Specialty generic and brand name medications	[0-50]% per Prescription or refill [and $[120-150] Copay per	[Not available]

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
that meet criteria of specialty drugs	Maintenance Drug Prescription or refill] [and [0-50]% per Maintenance Drug Prescription or refill]	
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative	0% Deductible waived per Prescription or refill	[Not available]

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.

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

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

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.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Copayment/Copay is 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 and Reconstructive 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. 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”. For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. Several types of deductibles may apply to this Policy and all are defined in this section. See the definitions for Individual In-Network Deductible, Family In-Network Deductible, Individual Out-of-Network Deductible, Family Out-of-Network Deductible.

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

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

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedure is considered Experimental or Investigational 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 its is proposed;
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- it is the subject of an on-going clinical trial, except as provided in the “Clinical Trials” section of this plan.

Family In-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

The **Family Out-of-Network Out-of-Pocket Maximum:** Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no

longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

Free-Standing Outpatient Surgical Facility

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

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

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians)

medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual In-Network Out-of-Pocket Maximum: Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Individual Out-of-Network Out of Pocket Maximum: Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

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

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification.

Injury means an accidental bodily injury.

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

Insured/Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

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

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- The provider's normal charge for a similar service or supply; or
- A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna; or.
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

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

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.

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

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

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

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

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

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons;or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons.

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

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

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

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

Pharmacy is a retail Pharmacy, or a mail-order Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

Policy Year is defined as a 12-month period that begins on January 1st of each year. Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

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

Primary Care Physician is a Physician:

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

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

Priority Review is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

Service Area is any place that is within the counties and/or zip code areas in the state of Tennessee that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Special Limits are limits applied to certain Covered Expenses in the form of an Annual, Lifetime, per visit, per day, or per event maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled "How The Policy Works".

Specialty Medication means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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.

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

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached 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 or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna in writing within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of placement for adoption or initiation of a suit of adoption, and paying any additional premium.
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents, and We must receive that application during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the Month in the Year following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next

Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on the Federally Facilitated Marketplace ("on marketplace" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- 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.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on the Federally Facilitated Marketplace ("off-marketplace plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the Federally Facilitated Marketplace, or of the Department of Health and Human Services (HHS), or its

instrumentalities as determined by the marketplace. In such cases, the marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or

- An eligible individual adequately demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move (including a move outside the service area of the individual's current plan); or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- [The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or

The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for intentional misrepresentations or intentionally omitted information.
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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- When the Insured no longer lives in the Service Area.

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

Continuation

If an Insured Person's eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability.

How The Policy Works

This section describes Deductibles and Copayments/Coinsurance and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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.

Participating Hospitals, Participating Physicians and Other Participating Providers.

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

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

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

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

If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible. Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.
- If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year.

Out of Pocket Maximums

The Out of Pocket Maximums are the amount of Coinsurance, Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of Maximum Reimbursable Charges, any penalties, or any amounts in excess of other benefit limits of this Policy.

- Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

- If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.

Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on Annual, Lifetime or payment Maximums which may apply to these specific Benefits.

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 Maximums;
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.
- Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.
- Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.

The Insured Person must satisfy any applicable penalty before benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition that is Authorized by Cigna, this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

In addition, the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification; and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;
  - Not for exercise; and
  - And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic ,and Speech Therapy)

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

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

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, manipulation of the spine, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the number of visits as stated in the Benefit Schedule.

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

Special Note:

Additional visits for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment; and
- Cigna authorizes this in advance.

Services for Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred 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 is 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

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

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

Benefits for 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 are payable up to the maximum number of visits as stated in the Benefit Schedule.

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

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

Special Note:
Additional visits for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Services for Mental, Emotional or Functional Nervous Disorders and Substance Abuse

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

In order to qualify for benefits, services for Mental, Emotional or Functional Nervous Disorders, ,or substance abuse must meet the following conditions:

- Services must be for the treatment of a Mental, Emotional or Functional Nervous Disorder, ,or substance abuse and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.

Dental Care

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

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

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

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

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

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

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Preventive Care Services (birth and older)

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including but not limited to the following:

- Routine physical exams.
- Annual mammogram.
- United States Preventive Services Task Force (USPSTF) for services rated "A" or "B", Advisory Committee on Immunization Practices (HRSA) recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

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

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 if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Hearing Aids

Hearing aids for children to age 18 are covered as specified in the Benefit Schedule.

Autism Spectrum Disorders

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

This Policy provides benefits for Covered Expenses for Insured Persons under age 12 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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

   Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
   a) self care and feeding,
   b) pragmatic, receptive, and expressive language,
   c) cognitive functioning,
   d) applied behavior analysis, intervention, and modification,

e) motor planning, and

f) sensory processing.

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

Organ and Tissue Transplants

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers contracted with Cigna for other services, but not for transplant services, are not covered.
The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- The donor, if the recipient is an Insured Person.

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion and a donor will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.

Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement as shown in the Plan Benefit Schedule.

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.
- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $200 per day.

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.

- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Clinical Trials

Benefits are payable for routine patient care costs related to an approved clinical trial (Phases I-IV)**,** for cancer or life-threatening diseases or conditions for an Insured who meets the following requirements:

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

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

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

For clinical trials, routine patient costs do not include—

1. the investigational item, device, or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. costs for the management of research relating to the clinical trial or study;
4. any portion of the clinical trial or study that is paid for by a government or a bio-technical, pharmaceutical, or medical industry;
5. coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;

6. extraneous expenses related to participation in the clinical trial; or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur.

If one or more in-network providers are participating in a clinical trial, Cigna may require that an Insured residing in Tennessee participate in the trial through a Tennessee participating in-network provider if that provider is willing to accept the Insured as a participant in the trial.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level only if the clinical trial is conducted outside the Insured's state of residence. A non-participating provider located in the Insured's state of residence will be reimbursed at the rate that the Insured's plan would otherwise pay a non-participating provider for covered services.

Treatment of Diabetes

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

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

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

To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.

- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

Private duty nursing services are not covered, even if provided as part of a home health care treatment program.

Injury While Intoxicated or Under the Influence of a Narcotic

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

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.

Mastectomy and Related Procedures

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

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

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

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- Inpatient or outpatient services of a private duty nurse.
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.

- 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.
- 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.
- Smoking cessation programs.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** for Insured Person's 19 and over, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems.
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically stated in this Policy.
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- 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.
- Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.

- All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Plan.
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage Therapy.**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.

- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except as otherwise stated in this Policy.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable Plan Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment or Coinsurance will apply to each Prescription Drug.

In the event that You request a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the “generic” Copayment or Coinsurance shown in the Schedule.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.

Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications are covered.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA); or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- infertility drugs;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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;
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- Drugs that are not on the Prescription Drug List;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);

- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition; growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 30-day supply for Specialty Medications and Self-Administered Injectable Drugs, at a home delivery Pharmacy unless limited by the drug manufacturer's packaging; or
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- 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.

Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.

Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

In the event that You or Your Physician requests a "brand-name" drug that has a generic equivalent, You will be financially responsible for the amount by which the cost of the "brand-name" drug exceeds the cost of the "generic" drug, plus the "generic" Copayment or Coinsurance shown in the Schedule.

All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.

Pharmacy Formulary Exception
Process/Prior Authorization – Coverage of New Drugs
Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior

Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

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

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

Pediatric Vision Services Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses per year, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

COORDINATION OF BENEFITS

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

Definitions

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

Plan

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

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

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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

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

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

Claim Determination Period

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this Plan is the Primary Plan, the amount this Plan pays for a Covered Expense will be determined without regard for the benefits payable under any other Plan.
- If this Plan is the Secondary Plan, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount paid by the Primary plan during a Claim Determination Period.

The difference between the amount that this Plan pays when it is the Secondary Plan and what it would have paid as the Primary Plan will be recorded as a benefit reserve for you. This benefit reserve will be used to pay any Covered Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide benefits under this Plan;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Covered Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Covered Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

If while covered under this Plan, you are also covered by another Cigna individual or group Plan, you will be entitled to the benefits of only one Plan. You may choose this Plan or the Plan under which you will be covered. Cigna will then refund any premium received under the other Plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the Plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this Plan is the Secondary Plan and Cigna pays for Covered Expenses that should have been paid by the Primary Plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

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.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits, you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

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

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

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within 180 days of receipt of the denial notice, to the following address:

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

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person’s medical condition.

Cigna’s Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

If the Insured Person is not satisfied with Cigna’s decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner’s office. The Commissioner may make a different determination regarding the Insured Person’s eligibility for an expedited external review. The Commissioner’s office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance

500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 180 days of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

Terms of the Policy

Entire Contract; Changes: 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 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not

receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

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

1. You fail to pay Your premiums as they become due or by the end of the 31 day grace period.
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, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Insured no longer lives in the Service Area.

Any cancellation shall be without prejudice for any claim for Covered Expense 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 this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise, You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

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

Certificate of Creditable Coverage: If coverage under this Policy terminates for any Insured Person, we will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. An Insured Person may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. To obtain a certificate call the toll-free customer service number on the back of your ID card. Such a certificate may help the Insured

Person to obtain future coverage. However, Cigna is responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations, made by any other health insurance issuer with respect to any coverage it provides, including whether or not or to what extent the information contained in the certificate is relevant to the other health insurance issuer's actions.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

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

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

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

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

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

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

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

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

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

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

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

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna CLAIM OFFICE.
  - YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
  - YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM.

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

Medical Benefits are assignable to the provider; when you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a

Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

We will recognize any assignment made under the Policy, if:

1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

When the Insured Person or their representative requests a required Medical Necessity determination prior to care, Cigna will notify the Insured Person or their representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify the Insured Person or their representative within 24 hours after receiving the request to specify what information is needed. The Insured person or their representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify the Insured Person or their representative of the expedited benefit determination within 48 hours after the Insured Person or their representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the Insured Person or their representative fails to follow Cigna's procedures for requesting a required preservice medical necessity determination, Cigna will notify them of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Insured Person or their representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for an Insured Person and they wish to extend the approval, the Insured Person or their representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the Insured Person or their representative requests such a determination, Cigna will notify them of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When an Insured Person or their representative requests a Medical Necessity determination after services have been rendered, Cigna will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

Postservice Claim Determinations

When an Insured Person or their representative requests payment for services which have been rendered, Cigna will notify them of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date the Insured Person or their representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical

Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Physical Examination and Autopsy: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy. In the case of death of an Insured Person, Cigna shall have the right and opportunity to make an autopsy where it is not prohibited by law.

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid.

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 30 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.

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	116.88	146.10
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	21	184.06	230.08
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	22	184.06	230.08
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	23	184.06	230.08
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	24	184.06	230.08
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	25	184.80	231.00
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	26	188.48	235.60
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	27	192.89	241.12
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	28	200.07	250.10
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	29	205.96	257.46
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	30	208.91	261.14
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	31	213.33	266.66
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	32	217.74	272.18
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	33	220.50	275.64
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	34	223.45	279.32
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	35	224.92	281.16
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	36	226.39	283.00
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	37	227.87	284.84
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	38	229.34	286.68

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HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	39	232.28	290.36
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	40	235.23	294.04
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	41	239.65	299.56
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	42	243.88	304.86
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	43	249.77	312.22
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	44	257.13	321.42
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	45	265.78	332.24
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	46	276.09	345.12
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	47	287.69	359.62
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	48	300.94	376.18
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	49	314.01	392.52
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	50	328.73	410.92
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	51	343.27	429.10
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	52	359.29	449.12
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	53	375.48	469.36
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	54	392.97	491.22
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	55	410.45	513.08
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	56	429.41	536.78
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	57	448.55	560.70

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Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
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Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	58	468.98	586.24
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	59	479.11	598.90
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	60	499.54	624.44
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	61	517.21	646.52
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	62	528.80	661.02
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	63	543.35	679.20
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	64	552.18	690.24
99248TN0020001	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	552.18	690.24
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	120.57	150.72
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	21	189.88	237.35
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	22	189.88	237.35
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	23	189.88	237.35
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	24	189.88	237.35
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	25	190.64	238.30
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	26	194.44	243.05
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	27	198.99	248.74
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	28	206.40	258.00
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	29	212.48	265.59
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	30	215.51	269.39

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Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	31	220.07	275.09
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	32	224.63	280.79
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	33	227.48	284.35
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	34	230.51	288.14
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	35	232.03	290.04
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	36	233.55	291.94
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	37	235.07	293.84
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	38	236.59	295.74
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	39	239.63	299.54
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	40	242.67	303.33
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	41	247.22	309.03
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	42	251.59	314.49
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	43	257.67	322.08
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	44	265.26	331.58
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	45	274.19	342.73
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	46	284.82	356.03
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	47	296.78	370.98
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	48	310.45	388.07
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	49	323.94	404.92

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Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	50	339.13	423.91
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	51	354.13	442.66
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	52	370.65	463.31
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	53	387.36	484.19
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	54	405.39	506.74
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	55	423.43	529.29
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	56	442.99	553.74
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	57	462.74	578.42
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	58	483.81	604.77
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	59	494.26	617.82
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	60	515.33	644.17
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	61	533.56	666.95
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	62	545.53	681.91
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	63	560.53	700.66
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	64	569.64	712.05
99248TN0020002	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	569.64	712.05
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	138.38	172.97
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	21	217.92	272.39
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	22	217.92	272.39

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Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	23	217.92	272.39
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	24	217.92	272.39
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	25	218.79	273.48
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	26	223.15	278.93
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	27	228.38	285.46
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	28	236.88	296.09
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	29	243.85	304.80
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	30	247.34	309.16
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	31	252.57	315.70
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	32	257.80	322.24
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	33	261.07	326.32
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	34	264.55	330.68
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	35	266.30	332.86
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	36	268.04	335.04
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	37	269.78	337.22
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	38	271.53	339.40
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	39	275.02	343.76
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	40	278.50	348.11
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	41	283.73	354.65

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Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	42	288.74	360.92
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	43	295.72	369.63
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	44	304.43	380.53
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	45	314.68	393.33
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	46	326.88	408.59
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	47	340.61	425.75
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	48	356.30	445.36
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	49	371.77	464.70
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	50	389.21	486.49
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	51	406.42	508.01
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	52	425.38	531.71
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	53	444.56	555.68
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	54	465.26	581.55
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	55	485.96	607.43
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	56	508.41	635.49
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	57	531.07	663.81
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	58	555.26	694.05
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	59	567.25	709.03
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	60	591.43	739.27

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	61	612.36	765.42
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	62	626.08	782.58
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	63	643.30	804.10
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	64	653.76	817.17
99248TN0020003	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	653.76	817.17
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	137.03	171.29
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	21	215.80	269.75
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	22	215.80	269.75
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	23	215.80	269.75
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	24	215.80	269.75
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	25	216.66	270.83
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	26	220.98	276.22
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	27	226.16	282.70
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	28	234.57	293.22
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	29	241.48	301.85
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	30	244.93	306.17
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	31	250.11	312.64
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	32	255.29	319.11
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	33	258.53	323.16

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	34	261.98	327.48
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	35	263.71	329.63
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	36	265.43	331.79
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	37	267.16	333.95
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	38	268.89	336.11
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	39	272.34	340.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	40	275.79	344.74
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	41	280.97	351.21
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	42	285.94	357.42
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	43	292.84	366.05
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	44	301.47	376.84
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	45	311.62	389.52
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	46	323.70	404.63
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	47	337.30	421.62
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	48	352.83	441.04
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	49	368.15	460.19
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	50	385.42	481.77
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	51	402.47	503.08
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	52	421.24	526.55

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	53	440.23	550.29
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	54	460.73	575.92
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	55	481.23	601.54
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	56	503.46	629.33
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	57	525.90	657.38
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	58	549.86	687.32
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	59	561.73	702.16
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	60	585.68	732.10
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	61	606.40	758.00
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	62	619.99	774.99
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	63	637.04	796.30
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	64	647.40	809.25
99248TN0020004	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	647.40	809.25
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	141.73	177.17
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	21	223.20	279.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	22	223.20	279.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	23	223.20	279.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	24	223.20	279.01
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	25	224.09	280.13

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	26	228.56	285.71
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	27	233.91	292.40
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	28	242.62	303.28
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	29	249.76	312.21
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	30	253.33	316.68
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	31	258.69	323.37
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	32	264.05	330.07
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	33	267.39	334.25
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	34	270.96	338.72
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	35	272.75	340.95
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	36	274.54	343.18
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	37	276.32	345.41
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	38	278.11	347.65
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	39	281.68	352.11
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	40	285.25	356.57
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	41	290.61	363.27
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	42	295.74	369.69
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	43	302.88	378.62
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	44	311.81	389.78

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	45	322.30	402.89
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	46	334.80	418.52
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	47	348.86	436.09
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	48	364.93	456.18
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	49	380.78	475.99
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	50	398.64	498.31
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	51	416.27	520.35
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	52	435.69	544.63
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	53	455.33	569.18
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	54	476.53	595.69
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	55	497.74	622.19
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	56	520.73	650.93
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	57	543.94	679.95
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	58	568.71	710.92
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	59	580.99	726.26
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	60	605.76	757.23
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	61	627.19	784.02
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	62	641.25	801.60
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	63	658.89	823.64

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	64	669.60	837.03
99248TN0020005	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	669.60	837.03
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	158.53	198.16
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	21	249.65	312.06
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	22	249.65	312.06
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	23	249.65	312.06
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	24	249.65	312.06
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	25	250.65	313.31
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	26	255.64	319.55
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	27	261.63	327.04
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	28	271.37	339.21
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	29	279.36	349.20
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	30	283.35	354.19
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	31	289.34	361.68
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	32	295.34	369.17
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	33	299.08	373.85
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	34	303.08	378.84
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	35	305.07	381.34
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	36	307.07	383.83

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	37	309.07	386.33
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	38	311.06	388.83
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	39	315.06	393.82
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	40	319.05	398.81
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	41	325.04	406.30
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	42	330.79	413.48
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	43	338.78	423.47
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	44	348.76	435.95
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	45	360.49	450.61
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	46	374.48	468.09
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	47	390.20	487.75
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	48	408.18	510.22
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	49	425.90	532.37
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	50	445.87	557.34
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	51	465.60	581.99
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	52	487.32	609.14
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	53	509.29	636.60
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	54	533.00	666.25
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	55	556.72	695.89

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	56	582.43	728.04
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	57	608.40	760.49
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	58	636.11	795.13
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	59	649.84	812.29
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	60	677.55	846.93
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	61	701.52	876.89
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	62	717.24	896.55
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	63	736.97	921.20
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	64	748.95	936.18
99248TN0020006	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	748.95	936.18
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	0-20	167.93	209.92
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	21	264.46	330.58
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	22	264.46	330.58
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	23	264.46	330.58
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	24	264.46	330.58
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	25	265.52	331.90
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	26	270.81	338.51
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	27	277.15	346.45
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	28	287.47	359.34

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	29	295.93	369.92
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	30	300.16	375.21
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	31	306.51	383.14
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	32	312.86	391.08
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	33	316.82	396.03
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	34	321.05	401.32
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	35	323.17	403.97
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	36	325.29	406.61
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	37	327.40	409.26
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	38	329.52	411.90
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	39	333.75	417.19
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	40	337.98	422.48
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	41	344.33	430.42
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	42	350.41	438.02
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	43	358.87	448.60
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	44	369.45	461.82
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	45	381.88	477.36
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	46	396.69	495.87
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	47	413.35	516.70

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	48	432.39	540.50
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	49	451.17	563.97
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	50	472.33	590.42
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	51	493.22	616.53
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	52	516.23	645.29
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	53	539.50	674.38
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	54	564.62	705.79
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	55	589.75	737.19
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	56	616.99	771.24
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	57	644.49	805.62
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	58	673.84	842.32
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	59	688.39	860.50
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	60	717.74	897.19
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	61	743.13	928.93
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	62	759.79	949.76
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	63	780.69	975.87
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	64	793.38	991.74
99248TN0020007	Rating Area 3	Tobacco User/Non-Tobacco User	65 and over	793.38	991.74
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	119.82	149.78

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	21	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	22	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	23	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	24	188.70	235.88
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	25	189.45	236.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	26	193.23	241.54
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	27	197.76	247.20
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	28	205.12	256.40
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	29	211.16	263.95
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	30	214.17	267.72
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	31	218.70	273.38
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	32	223.23	279.05
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	33	226.06	282.58
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	34	229.08	286.36
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	35	230.59	288.25
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	36	232.10	290.13
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	37	233.61	292.02
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	38	235.12	293.91
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	39	238.14	297.68

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	40	241.16	301.45
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	41	245.69	307.12
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	42	250.03	312.54
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	43	256.07	320.09
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	44	263.61	329.52
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	45	272.48	340.61
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	46	283.05	353.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	47	294.94	368.68
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	48	308.52	385.66
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	49	321.92	402.41
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	50	337.02	421.28
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	51	351.93	439.92
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	52	368.34	460.44
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	53	384.95	481.20
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	54	402.87	503.60
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	55	420.80	526.01
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	56	440.24	550.31
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	57	459.86	574.84
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	58	480.81	601.02

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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	59	491.19	614.00
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	60	512.13	640.18
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	61	530.25	662.82
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	62	542.14	677.68
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	63	557.04	696.32
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	64	566.10	707.64
99248TN0020001	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	566.10	707.64
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	123.62	154.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	21	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	22	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	23	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	24	194.67	243.33
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	25	195.45	244.30
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	26	199.34	249.17
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	27	204.01	255.01
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	28	211.61	264.50
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	29	217.84	272.29
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	30	220.95	276.18
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	31	225.62	282.02

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	32	230.29	287.86
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	33	233.21	291.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	34	236.33	295.40
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	35	237.89	297.35
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	36	239.44	299.30
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	37	241.00	301.24
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	38	242.56	303.19
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	39	245.67	307.08
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	40	248.79	310.98
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	41	253.46	316.82
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	42	257.94	322.41
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	43	264.17	330.20
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	44	271.95	339.93
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	45	281.10	351.37
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	46	292.01	365.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	47	304.27	380.32
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	48	318.29	397.84
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	49	332.11	415.12
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	50	347.68	434.59

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	51	363.06	453.81
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	52	380.00	474.98
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	53	397.13	496.39
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	54	415.62	519.51
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	55	434.11	542.63
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	56	454.17	567.69
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	57	474.41	593.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	58	496.02	620.00
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	59	506.73	633.39
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	60	528.33	660.40
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	61	547.02	683.76
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	62	559.29	699.09
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	63	574.67	718.31
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	64	584.01	729.99
99248TN0020002	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	584.01	729.99
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	141.87	177.33
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	21	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	22	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	23	223.41	279.26

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	24	223.41	279.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	25	224.30	280.38
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	26	228.77	285.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	27	234.13	292.66
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	28	242.85	303.56
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	29	250.00	312.49
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	30	253.57	316.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	31	258.93	323.66
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	32	264.29	330.36
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	33	267.65	334.55
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	34	271.22	339.02
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	35	273.01	341.26
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	36	274.79	343.49
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	37	276.58	345.72
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	38	278.37	347.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	39	281.94	352.43
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	40	285.52	356.89
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	41	290.88	363.60
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	42	296.02	370.02

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	43	303.17	378.96
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	44	312.10	390.13
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	45	322.60	403.25
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	46	335.12	418.89
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	47	349.19	436.48
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	48	365.28	456.59
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	49	381.14	476.42
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	50	399.01	498.76
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	51	416.66	520.82
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	52	436.10	545.12
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	53	455.76	569.69
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	54	476.98	596.22
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	55	498.20	622.75
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	56	521.22	651.51
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	57	544.45	680.56
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	58	569.25	711.55
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	59	581.54	726.91
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	60	606.33	757.91
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	61	627.78	784.72

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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	62	641.86	802.31
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	63	659.51	824.38
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	64	670.23	837.78
99248TN0020003	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	670.23	837.78
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	140.49	175.61
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	21	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	22	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	23	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	24	221.24	276.55
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	25	222.12	277.66
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	26	226.55	283.19
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	27	231.86	289.82
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	28	240.49	300.61
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	29	247.57	309.46
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	30	251.11	313.88
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	31	256.42	320.52
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	32	261.73	327.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	33	265.05	331.31
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	34	268.59	335.73

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	35	270.36	337.94
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	36	272.13	340.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	37	273.90	342.37
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	38	275.67	344.58
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	39	279.20	349.01
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	40	282.74	353.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	41	288.05	360.07
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	42	293.14	366.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	43	300.22	375.28
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	44	309.07	386.34
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	45	319.47	399.34
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	46	331.86	414.83
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	47	345.80	432.25
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	48	361.73	452.16
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	49	377.44	471.79
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	50	395.13	493.92
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	51	412.61	515.77
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	52	431.86	539.83
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	53	451.33	564.16

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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	54	472.35	590.43
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	55	493.37	616.71
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	56	516.15	645.19
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	57	539.16	673.95
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	58	563.72	704.65
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	59	575.89	719.86
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	60	600.45	750.56
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	61	621.68	777.11
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	62	635.62	794.53
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	63	653.10	816.38
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	64	663.72	829.65
99248TN0020004	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	663.72	829.65
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	145.31	181.63
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	21	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	22	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	23	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	24	228.83	286.03
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	25	229.75	287.17
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	26	234.32	292.89

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	27	239.81	299.76
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	28	248.74	310.91
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	29	256.06	320.07
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	30	259.72	324.64
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	31	265.21	331.51
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	32	270.71	338.37
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	33	274.14	342.66
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	34	277.80	347.24
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	35	279.63	349.53
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	36	281.46	351.82
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	37	283.29	354.11
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	38	285.12	356.39
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	39	288.78	360.97
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	40	292.44	365.55
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	41	297.94	372.41
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	42	303.20	378.99
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	43	310.52	388.14
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	44	319.68	399.58
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	45	330.43	413.03

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HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	46	343.25	429.05
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	47	357.66	447.06
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	48	374.14	467.66
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	49	390.38	487.97
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	50	408.69	510.85
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	51	426.77	533.45
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	52	446.68	558.33
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	53	466.81	583.50
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	54	488.55	610.67
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	55	510.29	637.85
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	56	533.86	667.31
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	57	557.66	697.06
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	58	583.06	728.80
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	59	595.64	744.54
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	60	621.04	776.29
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	61	643.01	803.74
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	62	657.43	821.76
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	63	675.51	844.36
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	64	686.49	858.09

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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	686.49	858.09
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	162.52	203.16
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	21	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	22	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	23	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	24	255.94	319.93
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	25	256.96	321.21
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	26	262.08	327.61
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	27	268.23	335.29
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	28	278.21	347.76
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	29	286.40	358.00
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	30	290.49	363.12
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	31	296.63	370.80
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	32	302.78	378.48
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	33	306.62	383.28
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	34	310.71	388.40
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	35	312.76	390.95
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	36	314.81	393.51
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	37	316.85	396.07

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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	Individual Tobacco Rate*
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	38	318.90	398.63
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	39	323.00	403.75
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	40	327.09	408.87
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	41	333.23	416.55
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	42	339.12	423.91
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	43	347.31	434.15
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	44	357.55	446.94
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	45	369.58	461.98
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	46	383.91	479.90
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	47	400.03	500.05
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	48	418.46	523.09
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	49	436.63	545.80
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	50	457.11	571.39
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	51	477.33	596.67
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	52	499.59	624.50
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	53	522.12	652.66
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	54	546.43	683.05
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	55	570.75	713.44
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	56	597.11	746.40

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	57	623.73	779.67
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	58	652.14	815.18
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	59	666.21	832.78
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	60	694.62	868.29
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	61	719.19	899.00
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	62	735.32	919.16
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	63	755.53	944.43
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	64	767.82	959.79
99248TN0020006	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	767.82	959.79
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	0-20	172.16	215.20
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	21	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	22	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	23	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	24	271.12	338.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	25	272.20	340.26
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	26	277.63	347.03
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	27	284.13	355.17
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	28	294.71	368.38
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	29	303.38	379.23

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	30	307.72	384.65
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	31	314.23	392.79
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	32	320.73	400.92
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	33	324.80	406.00
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	34	329.14	411.42
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	35	331.31	414.14
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	36	333.48	416.85
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	37	335.65	419.56
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	38	337.82	422.27
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	39	342.15	427.69
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	40	346.49	433.11
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	41	353.00	441.25
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	42	359.23	449.04
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	43	367.91	459.89
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	44	378.75	473.44
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	45	391.50	489.37
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	46	406.68	508.35
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	47	423.76	529.70
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	48	443.28	554.10

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	49	462.53	578.16
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	50	484.22	605.28
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	51	505.64	632.05
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	52	529.23	661.53
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	53	553.08	691.36
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	54	578.84	723.55
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	55	604.60	755.75
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	56	632.52	790.65
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	57	660.72	825.90
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	58	690.81	863.52
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	59	705.73	882.16
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	60	735.82	919.77
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	61	761.85	952.31
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	62	778.93	973.66
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	63	800.35	1000.43
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	64	813.36	1016.70
99248TN0020007	Rating Area 4	Tobacco User/Non-Tobacco User	65 and over	813.36	1016.70
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	113.26	141.57
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	21	178.36	222.95

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	22	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	23	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	24	178.36	222.95
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	25	179.07	223.84
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	26	182.64	228.30
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	27	186.92	233.65
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	28	193.88	242.35
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	29	199.58	249.48
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	30	202.44	253.05
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	31	206.72	258.40
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	32	211.00	263.75
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	33	213.68	267.09
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	34	216.53	270.66
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	35	217.96	272.44
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	36	219.38	274.23
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	37	220.81	276.01
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	38	222.24	277.80
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	39	225.09	281.36
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	40	227.94	284.93

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	41	232.22	290.28
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	42	236.33	295.41
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	43	242.03	302.54
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	44	249.17	311.46
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	45	257.55	321.94
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	46	267.54	334.43
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	47	278.78	348.47
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	48	291.62	364.52
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	49	304.28	380.35
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	50	318.55	398.19
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	51	332.64	415.80
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	52	348.16	435.20
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	53	363.85	454.82
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	54	380.80	476.00
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	55	397.74	497.18
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	56	416.11	520.14
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	57	434.66	543.33
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	58	454.46	568.08
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	59	464.27	580.34

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	60	484.07	605.09
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	61	501.19	626.49
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	62	512.43	640.54
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	63	526.52	658.15
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	64	535.08	668.85
99248TN0020001	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	535.08	668.85
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	116.83	146.04
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	21	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	22	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	23	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	24	183.99	229.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	25	184.73	230.91
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	26	188.41	235.51
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	27	192.82	241.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	28	200.00	250.00
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	29	205.88	257.36
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	30	208.83	261.04
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	31	213.24	266.56
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	32	217.66	272.08

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	33	220.42	275.53
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	34	223.36	279.21
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	35	224.84	281.05
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	36	226.31	282.89
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	37	227.78	284.73
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	38	229.25	286.57
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	39	232.20	290.25
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	40	235.14	293.93
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	41	239.55	299.45
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	42	243.79	304.74
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	43	249.67	312.10
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	44	257.03	321.30
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	45	265.68	332.11
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	46	275.99	344.99
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	47	287.58	359.47
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	48	300.82	376.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	49	313.89	392.36
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	50	328.61	410.76
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	51	343.14	428.93

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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	52	359.15	448.94
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	53	375.34	469.18
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	54	392.82	491.03
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	55	410.30	512.88
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	56	429.25	536.57
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	57	448.38	560.49
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	58	468.81	586.01
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	59	478.93	598.66
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	60	499.35	624.19
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	61	517.01	646.27
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	62	528.60	660.76
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	63	543.14	678.93
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	64	551.97	689.97
99248TN0020002	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	551.97	689.97
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	134.09	167.61
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	21	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	22	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	23	211.16	263.95
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	24	211.16	263.95

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	25	212.00	265.01
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	26	216.23	270.28
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	27	221.30	276.62
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	28	229.53	286.91
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	29	236.29	295.36
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	30	239.67	299.58
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	31	244.73	305.92
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	32	249.80	312.25
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	33	252.97	316.21
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	34	256.35	320.44
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	35	258.04	322.55
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	36	259.73	324.66
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	37	261.42	326.77
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	38	263.11	328.88
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	39	266.48	333.10
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	40	269.86	337.33
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	41	274.93	343.66
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	42	279.79	349.73
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	43	286.54	358.18

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	44	294.99	368.74
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	45	304.92	381.14
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	46	316.74	395.93
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	47	330.04	412.55
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	48	345.25	431.56
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	49	360.24	450.30
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	50	377.13	471.41
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	51	393.81	492.27
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	52	412.18	515.23
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	53	430.77	538.46
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	54	450.83	563.53
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	55	470.89	588.61
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	56	492.64	615.80
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	57	514.60	643.25
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	58	538.04	672.54
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	59	549.65	687.06
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	60	573.09	716.36
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	61	593.36	741.70
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	62	606.66	758.33

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	63	623.34	779.18
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	64	633.48	791.85
99248TN0020003	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	633.48	791.85
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	132.78	165.98
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	21	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	22	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	23	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	24	209.11	261.39
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	25	209.95	262.44
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	26	214.13	267.66
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	27	219.15	273.94
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	28	227.30	284.13
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	29	233.99	292.50
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	30	237.34	296.68
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	31	242.36	302.95
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	32	247.38	309.22
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	33	250.51	313.15
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	34	253.86	317.33
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	35	255.53	319.42

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	36	257.21	321.51
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	37	258.88	323.60
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	38	260.55	325.69
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	39	263.90	329.87
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	40	267.24	334.06
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	41	272.26	340.33
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	42	277.07	346.34
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	43	283.76	354.71
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	44	292.13	365.16
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	45	301.95	377.45
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	46	313.67	392.09
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	47	326.84	408.55
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	48	341.89	427.37
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	49	356.74	445.93
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	50	373.47	466.84
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	51	389.99	487.49
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	52	408.18	510.23
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	53	426.58	533.24
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	54	446.45	558.07

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	55	466.32	582.90
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	56	487.85	609.82
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	57	509.60	637.01
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	58	532.81	666.02
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	59	544.31	680.40
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	60	567.52	709.41
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	61	587.60	734.51
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	62	600.77	750.97
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	63	617.29	771.62
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	64	627.33	784.17
99248TN0020004	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	627.33	784.17
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	137.34	171.67
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	21	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	22	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	23	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	24	216.28	270.35
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	25	217.15	271.43
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	26	221.47	276.84
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	27	226.66	283.33

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	28	235.10	293.87
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	29	242.02	302.52
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	30	245.48	306.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	31	250.67	313.34
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	32	255.86	319.82
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	33	259.10	323.88
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	34	262.56	328.20
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	35	264.29	330.37
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	36	266.02	332.53
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	37	267.75	334.69
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	38	269.48	336.86
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	39	272.95	341.18
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	40	276.41	345.51
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	41	281.60	352.00
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	42	286.57	358.21
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	43	293.49	366.86
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	44	302.14	377.68
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	45	312.31	390.39
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	46	324.42	405.53

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	47	338.05	422.56
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	48	353.62	442.02
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	49	368.97	461.22
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	50	386.28	482.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	51	403.36	504.20
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	52	422.18	527.72
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	53	441.21	551.51
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	54	461.76	577.20
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	55	482.30	602.88
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	56	504.58	630.73
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	57	527.07	658.84
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	58	551.08	688.85
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	59	562.98	703.72
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	60	586.98	733.73
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	61	607.75	759.68
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	62	621.37	776.72
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	63	638.46	798.07
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	64	648.84	811.05
99248TN0020005	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	648.84	811.05

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
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	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	153.61	192.02
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	21	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	22	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	23	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	24	241.91	302.39
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	25	242.88	303.60
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	26	247.72	309.65
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	27	253.52	316.90
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	28	262.96	328.70
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	29	270.70	338.37
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	30	274.57	343.21
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	31	280.37	350.47
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	32	286.18	357.73
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	33	289.81	362.26
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	34	293.68	367.10
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	35	295.61	369.52
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	36	297.55	371.94
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	37	299.48	374.36
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	38	301.42	376.78

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	39	305.29	381.62
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	40	309.16	386.45
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	41	314.97	393.71
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	42	320.53	400.67
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	43	328.27	410.34
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	44	337.95	422.44
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	45	349.32	436.65
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	46	362.87	453.59
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	47	378.11	472.64
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	48	395.52	494.41
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	49	412.70	515.88
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	50	432.05	540.07
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	51	451.16	563.96
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	52	472.21	590.27
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	53	493.50	616.88
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	54	516.48	645.60
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	55	539.46	674.33
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	56	564.38	705.48
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	57	589.53	736.92

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	58	616.39	770.49
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	59	629.69	787.12
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	60	656.54	820.69
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	61	679.77	849.72
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	62	695.01	868.77
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	63	714.12	892.66
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	64	725.73	907.17
99248TN0020006	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	725.73	907.17
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	0-20	162.73	203.41
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	21	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	22	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	23	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	24	256.26	320.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	25	257.29	321.61
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	26	262.41	328.02
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	27	268.56	335.71
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	28	278.55	348.20
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	29	286.75	358.45
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	30	290.86	363.57

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	31	297.01	371.26
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	32	303.16	378.95
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	33	307.00	383.76
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	34	311.10	388.88
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	35	313.15	391.44
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	36	315.20	394.01
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	37	317.25	396.57
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	38	319.30	399.13
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	39	323.40	404.26
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	40	327.50	409.38
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	41	333.65	417.07
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	42	339.54	424.44
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	43	347.74	434.69
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	44	358.00	447.50
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	45	370.04	462.56
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	46	384.39	480.50
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	47	400.53	500.68
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	48	418.99	523.74
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	49	437.18	546.48

Rates Table Template v2.2	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*				
	If you are a community rating state, select Family Option under Age and fill in all columns.				
	If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.				
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.				
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.				
HIOS Issuer ID*	99248				
Federal TIN*	59-1031071				
Rate Effective Date*	01/01/2014				
Rate Expiration Date*	12/31/2014				

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***	**Individual Tobacco Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	**Required:** Enter the rate of an Individual tobacco enrollee on a plan
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	50	457.68	572.11
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	51	477.92	597.42
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	52	500.22	625.28
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	53	522.77	653.47
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	54	547.12	683.90
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	55	571.46	714.34
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	56	597.85	747.33
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	57	624.51	780.64
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	58	652.95	816.20
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	59	667.04	833.82
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	60	695.49	869.38
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	61	720.09	900.13
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	62	736.23	920.31
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	63	756.48	945.61
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	64	768.78	960.99
99248TN0020007	Rating Area 6	Tobacco User/Non-Tobacco User	65 and over	768.78	960.99

Cigna Health and Life Insurance Company may change the premiums of this Policy after 30 days written notice to the Insured Person. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You.

Cigna Health and Life Insurance Company ("Cigna")
[Tennessee] [Plan Name][s]

If You Wish To Cancel Or If You Have Questions

If You are not satisfied, for any reason, with the terms of this Policy You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any premium You have paid. This Policy will then be null and void. If You wish to correspond with Us for this or any other reason, write:

Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630-3365

Include Your Cigna identification number with any correspondence. This number can be found on Your Cigna identification card.

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health And Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. 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 or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. **Coverage under this Policy is effective at 12:01 a.m. [Eastern time] on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

[signature] [Name] [President] [signature] [Name], [Secretary]

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) 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 Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 provider.

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Introduction

About This Policy

Your medical coverage is provided under a Policy issued by Cigna Health and Life Insurance Company ("Cigna"). This Policy is a legal contract between You and Us.

Under this Policy, "We", "Us", and "Our" mean Cigna. "You" or "Your" refers to the Policyholder whose application has been accepted by Us under the Policy issued. When We use the term "Insured Person" in this Policy, We mean You and any eligible Family Member(s) who are covered under this Policy. [You and all Family Member(s) covered under this Policy are listed on the Policy specification page.

The benefits of this Policy are provided only for those services that are Medically Necessary as defined in this Policy and for which the Insured Person has benefits. The fact that a Physician prescribes or orders a service does not, in itself, mean that the service is Medically Necessary or that the service is a Covered Service. Consult this Policy or phone Us at the number shown on Your Cigna identification card if You have any questions regarding whether services are covered.

This Policy contains many important terms (such as "Medically Necessary" and "Covered Service") that are defined in the section entitled "Definitions". Before reading through this Policy, be sure that You understand the meanings of these words as they pertain to this Policy.

We provide coverage to You under this Policy based upon the answers submitted by You and Your Family Member(s) on Your signed individual application. In consideration for the payment of the premiums stated in this Policy, We will provide the services and benefits listed in this Policy to You and Your Family Member(s) covered under the Policy.

[If, within 2 years after the Effective Date of Your participation in the Policy, We discover any fraud or material facts that were INTENTIONALLY misrepresented or that You or Your Family Member (s) knew, but intentionally 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 of the insured added within 31 days after birth), We discover any 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. Rescission of Your coverage will result in denial of all pending claims and, if claim payments exceed total premiums paid, then claims previously paid by Cigna will be retroactively denied, obligating You to pay the provider in full for services rendered at the provider's regular billed rate, not at the Cigna Negotiated Rate.

Choice of Hospital and Physician: Nothing contained in this Policy restricts or interferes with an Insured Person's right to select the Hospital or Physician of their choice. [You may pay more for Covered Services, however, if the Insured Person receives them from a Hospital or Physician that is a Non-Participating Provider. [REMOVE FOR EPO/OAP-INN PLANS]][However, non-emergency services from a Non-Participating Provider are not covered by this Plan.[USE FOR EPO/OAP-INN PLANS]]

THIS IS AN [EXCLUSIVE PROVIDER][NETWORK-ONLY]PLAN

That means this Plan does not provide benefits for any services You receive from an Out-of-Network Provider except:

- Services for Stabilization and initial treatment of a Medical Emergency
- Medically Necessary services that is not available through an In-Network Provider

In-Network Providers include Physicians, Hospitals, and other health care facilities. Check the provider directory, available on mycigna.com, or call the number on Your ID card to determine if a Provider is In-Network. You can also ask the Provider directly.]

[About Health Savings Accounts

This Health Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow You, if You are an eligible individual, to take advantage of the income tax benefits available to You when You establish an HSA and use the money You deposit into the HSA to pay for qualified medical expenses as allowed under federal tax law.

NOTICE: Cigna does not provide tax advice. If You intend to purchase this Plan to use with an HSA for tax purposes, You should consult with Your tax advisor about whether You are eligible and whether Your HSA meets all legal requirements.

Cigna has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Cigna believes that the Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should You purchase this Plan in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, You may not be eligible for the income tax benefits associated with an HSA. In this instance, You may have adverse income tax consequences with respect to Your HSA for all years in which You were not eligible. However, if there was such a ruling, or if government requirements for a high deductible health plan change, Cigna intends to amend the Health Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. Any changes to the Plan to meet Internal Revenue Service requirements will not be effective until such changes have been filed and approved with the appropriate regulatory authorities, as necessary. A change in the Plan’s premiums may also be required as a result of a change in the Plan.]

Important Information Regarding Benefits

Prior Authorization Program

Cigna provides You with a comprehensive personal health solution medical management program which focuses on improving quality outcomes and maximizes value for You.

Prior Authorization For Inpatient Services

Prior Authorization is required for all non emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A [PENALTY][OR][LACK OF COVERAGE FOR THE SERVICES PROVIDED].

Prior Authorization can be obtained by You, Your Family Member(s) or the Provider by calling the number on the back of Your ID card.

To verify Prior Authorization requirements for inpatient services, including which other types of facility admissions require Prior Authorization, You can:

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

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 Of 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][LACK OF COVERAGE FOR THE SERVICES PROVIDED].

Prior Authorization can be obtained by You, your Family Member(s) or the Provider by calling the number on the back of Your ID card. Outpatient Prior Authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services require Prior Authorization, You can:

- call Cigna at the number on the back of your ID card, or
- check mycigna.com, under “View Medical Benefit Details"

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Policy, such as limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Retrospective Review

If Prior Authorization was not performed Cigna will use retrospective review to determine if a scheduled or Emergency admission was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Policy. If it is determined that a service was not Medically Necessary, the Insured Person is responsible for payment of the charges for those services.

Prior Authorization—Prescription Drugs: Certain Prescription Drugs also may require Prior Authorization by Cigna. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. [Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.] If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

BENEFIT SCHEDULE[OAP/HSP/Metal Plans VERSION]

Following is a Benefit Schedule of the Policy. The Policy sets forth, in more detail, the rights and obligations of both You, your Family Member(s) and Cigna. It is, therefore, important that all Insured Person's **READ THE ENTIRE POLICY CAREFULLY!**

NOTE:
The benefits outlined in the table below show the payment for Covered Expenses. Coinsurance amounts shown below are Your responsibility after any applicable [deducible][copayment][access fee][additional deductible][has][have]been met, unless otherwise indicated. Copayment amounts shown are also Your responsibility.

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	
Medical Benefits		
Annual Plan Deductible Individual Family [Please Note: Additional Deductibles may apply to specific benefits.]	**In-Network Deductible** $[0-25,000] $[0-50,000]	**Out-of-Network Deductible** [$[0-50,000]] [$[0-100,000]]
[Additional Deductibles] [Some services may require a deductible for that service, and be subject to the [Annual Plan Deductible. Refer to the following pages of this Benefit Schedule for benefits on specific services.]	[Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.]	
Coinsurance [The coinsurance level for specialty Physician inpatient/outpatient physician services will differ between CCN and Non-CCN designated specialist services. The term Cigna Care Network (CCN) refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.]	[0-40]%	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	
[Primary Care Provider (PCP)]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[You and Your Family Members pay [0-50]% after the Policy Deductible.]
[CCN-designated PCP]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[Not Available]
[Specialist]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[You and Your Family Members pay [0-50]% after the Policy Deductible.]
[CCN-designated specialist]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[Not Available]
[Other Covered Services]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]	[You and Your Family Members pay [0-50]% of Charges after the Policy Deductible.]
Out-of-Pocket Maximum	**In-Network Out-of-Pocket Maximum**	**Out-of-Network Out-of-Pocket Maximum**
Individual	[$[0-30,000]] [Not Applicable]	[$[0-unlimited]] [Not Applicable]
Family	[$[0- 60,000]] [Not Applicable]	[$[0-unlimited]] [Not Applicable]
	[The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.]	[The following do not accumulate to the Out-of-Network Out of Pocket Maximum: [Deductibles,] [Copayments,] [Pharmacy charges][for all Except Essential Health Benefits,] [and] [Mental Health] [and] [Substance Abuse charges][Access Fees,][Charges for Infusion and Injectable Specialty Prescription Medications][Penalties] and Policy Maximums.]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
Prior Authorization Program		
Prior Authorization – Inpatient Services	**Your Provider must obtain approval** for inpatient admissions; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for inpatient admission; or **You may be assessed [a] $[500-$1,000], [penalty]** for non-compliance.
Prior Authorization – Outpatient Services NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services for more information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for outpatient procedures and diagnostic testing; or **Your Provider may be assessed a penalty** for non-compliance.	**You and Your Family Member(s) must obtain approval** for certain outpatient procedures and services; or **You may be assessed [a] $[50-$500], [penalty]** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details.	0% Deductible waived	[0-50]% [Deductible waived][Not Covered]
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than [19]years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits		
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	[0-50%% per exam] [Deductible waived]	[You pay all but $30 per exam] [Not Covered]
Eyeglasses and Lenses for Children	[0-50% per pair] [Deductible waived]	[Not Covered]
Frames		[You pay all but $30 per frame]
Single Vision		[You pay all but $25 per pair]
Lined Bifocal		[You pay all but $35 per pair]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
Lined Trifocal or Lenticular [Limited to one pair per year] **Contact Lenses for Children** Elective Therapeutic [Limited to one pair per year] **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	[0-50% per pair] [Deductible waived]	[You pay all but $45 per pair] [Not Covered] [You pay all but $75 per pair] [You pay all but $225 per pair]
Physician Services [Primary Care Physician (PCP) services] [Services of a specialist[, with PCP Referral and/or Plan Authorization] **Office Visit** **[(including [allergy testing and treatment/injections][and][lab and x-ray tests][and surgery]done in the office)]** **[Primary Care][Physician] [(PCP)]** [Non-Cigna Care Designation (CCN) PCP] **[Primary Care Physician (PCP) with CCN designation]**	[(No Referral Required)] [(PCP Referral or Plan Authorization is [NOT]required)] [$[0-250] Copayment] per office visit; [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250] Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [50-100]%] [visits over [5-15] per Year: [50-100]%] [$[0-250] Copayment] [per office visit] [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%]	[0-50]% [Not Covered] [Not Available]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual]Deductible [and any additional deductible(s)]unless specifically waived.	IN-NETWORK – YOU PAY (Based on Cigna contract allowance) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK – YOU PAY (Based on Maximum Reimbursable Charge)
	[visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	
Specialist, (including consultant, referral and second opinion services)[, **with PCP Referral and/or Plan Authorization]**	[$[0-250] Copayment] [per office visit] [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[[0-50]%] [Not Covered]
[Specialist, (including consultant, referral and second opinion services) **with CCN designation** [, **with PCP Referral and/or Plan Authorization]]** **[Note:** if a Copayment applies for OB/GYN visits: If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed [with a Cigna Care Designation, Your or Your Family member will pay the CCN specialist copay. If your doctor is listed] as a [non-CCN] specialist, You or Your Family Member will pay the [non-CCN] specialist Copayment.]	[$[0-250] Copayment][per office visit] [[0-50]%] [Deductible waived] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200] Copay] [all visits after the first [1-10] per Year: [50-100]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	[Not Available]
Physician Services, continued [Surgery in Physician's office]		
[Outpatient Professional Fees for Surgery] [(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy]	[[0-40]%]][included in Office Visit copayment] [Deductible waived]	[[0-50]%] [Not Covered]
Inpatient Surgery, Anesthesia, Radiation Therapy[, Chemotherapy]	[[0-40]%] [included in outpatient facility copayment] [Deductible waived]	

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In-hospital visits **[Allergy testing and treatment/injections]**	[0-40]% [Deductible waived] [0-40]% [Deductible waived] [[0-40]%] [included in Office Visit copayment] [Deductible waived]	[[0-50]%][Not Covered] [[0-50]%][Not Covered] [[0-50]%][Not Covered] [[0-50]%][Not Covered]
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years** **Note:** Services necessary to select, fit and adjust the hearing aid are included in the benefit.	[[0-50]%]	[0-50]% [Not Covered]
Hospital Services **Inpatient Hospital Services** [Facility Charges] [Professional Charges] **Emergency Admissions** [Facility Charges] [Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [$[500-5,000] Additional Deductible per admission, then][0-50]%] [Included in facility per-day copayment] [$[500-$1,5,000] Additional Deductible per admission, then][0-50%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Not Covered] [$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Not Covered] In-Network benefit level until transferable to an Participating In-Network Hospital then [[0-50]%][Not Covered] [In-Network benefit level until transferable to an In-Network Hospital then [[0-50]% [Not Covered]
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and	[$[500-2,500] Additional Deductible per	[$[500-2,500] Additional Deductible per

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Outpatient Hospital Facilities	[service][visit][admission] then][[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[service][visit][admission] then][[0-50]%] [to a maximum payment of $[500-1,500] per [service][visit][admission]] [Not Covered]
Emergency Services **Emergency Room** **Ambulance** [emergency transportation [to the nearest facility][capable of handling the emergency][only.]]	[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]][[0-50]%]] [0-50]%[for [Ground][or]Air][transport].	In-network benefit level for an emergency medical condition, otherwise [[$[50-500] [Access Fee, waived if admitted]per visit [then]][[0-50]%]] In-network benefit level for an emergency medical condition, otherwise [[0-50]%] [for [[Ground][or][Air]transport].
Urgent Care	[$[25-250] Copayment per visit] [then] [[0-50]%]	In-network benefit level for an emergency medical condition, otherwise [$[25-250] Copayment per visit] [then] [[0-50]%]
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[[0-50]%] [MRI:] [MRA:] [PET:] [CT Scan:] [Nuclear Medicine:] [$[100-1,000] Copayment per scan]	[[0-50]%] [Not Covered]
All Other Laboratory and Radiology Services Facility and interpretation charges Physician's Office	[$[0-250] Copayment] [[0-50]%][Subject to PCP/specialist office visit benefit] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]

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Free-standing/Independent lab or x-ray facility	[[0-50]%] [Deductible waived] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]
Outpatient hospital lab or x-ray	[[0-50]%] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent/ X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]	[[0-50]%] [Not Covered]
Short-Term Rehabilitative Services [Physical,] [Occupational,] [Speech,][and Chiropractic] [Therapy] [Acupuncture][/Acupressure] [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined.] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[$[0-250] Copayment] [PCP][or][specialist office visit benefit applies] [[0-50]%] [All except [$10-$50] Per Insured Person, per visit.]	[0-50]% [Not Covered] [All except [$10-$50] Per Insured Person, per visit.]
Cardiac & Pulmonary Rehabilitation [Maximum of [25-60] [visits] per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined] [Limits based on Medical Necessity guidelines]	[0-50]% [$[10-200] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except$[10-50] per [day] [visit].]	[[0-50]%][All except$[10-50] per visit] [Not Covered]
[Acupuncture][/Acupressure] [Maximum of [10-40] [visits] per Insured Person, per calendar year for [all therapies,][In- and Out-of-Network combined.]]	[$[0-200] Copayment] [PCP][or][specialist]office visit benefit applies][per visit] [[50-100]%] [All except [$10-$50] Per Insured Person, per visit.]	[[0-50]%] [All except [$10-$50] Per Insured Person, per visit.] [Not Covered]]

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Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[0-50]%	[[0-50]%] [Not Covered]]
Habilitative Services Including **[Physical,] [Occupational,] [Speech] [Therapy]** [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy, In- and Out-of-Network combined.] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[0-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per visit.]	[[0-50]%] [All except $[10-50] Per Insured Person, per visit.] [Not covered]
Womens' Contraceptive Services, Family Planning and Sterilization	[No charge, no Deductible]	[[0-50]%][Not Covered]
Male Sterilization	Copay or Coinsurance applies for specific benefit provided	[[0-50]%] [Not covered]
Maternity (Pregnancy and Delivery) /Complications of Pregnancy Initial Office Visit to confirm pregnancy [and subsequent prenatal visits billed separately from the "global" fee]

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Prenatal testing or treatment billed separately from "global" fee Postnatal visit or treatment billed separately from "global" fee	admission, then][0-50]% [0-50]% [Deductible waived] [$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	Deductible per admission, then][[0-50]%][Not Covered] [[0-50]%][Not Covered] [Not Covered]
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Also includes anesthesia for dental procedures for a child under age 8.	[0-50]%	[[0-50]%] [Not Covered]
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-50]%	[0-50]%
Medical Services for Treatment of Phenylketonuria (PKU)	[0-50]%	[0-15]%
Inpatient Services at Other Health Care Facilities [Including] Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities [Maximum of [20-100] days per Insured Person per calendar year {combined In- and Out-of-Network }for all facilities listed]	[$[500-5000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]	[$[500-5000] Additional Deductible per admission, then] [[0-50]%] [Not Covered]

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	AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS[AND ACCESS FEES], ARE THE INSURED PERSON'S RESPONSIBILITY	
Home Health Services [Maximum [20- 100] [days] [visits] per Insured Person, per calendar year.] [Maximum [4-16] hours per day] [Maximum [2-8] visits per day]	[0-50]%	[[0-50]%] [Not Covered]
Durable Medical Equipment	[0-50]%	[[0-50]%] [Not Covered]
Prosthetics	[0-50]%	[[0-50]%][Not Covered]
Hospice Inpatient Outpatient	[[0-50]%][Inpatient Hospital Services benefit applies] [[0-50]%][$[25-250] Copayment per [day][visit] [Deductible waived]	[[$500-5000] Additional Deductible per admission, then][[0-50]%][Not Covered] [[0-50]%][Not Covered]
Dialysis Inpatient Outpatient	Inpatient Hospital Services benefit applies [$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]	[[$500-5000] Additional Deductible per admission, then][[0-50]%] [[0-50]%] [Not Covered]
Autism Spectrum Disorders [For Insured Persons [under age 2-25 only]] Diagnosis of Autism Spectrum Disorder Office Visit	[PCP or Specialist Office Visit benefit applies][$[0-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-	[[0-50]%][Not Covered]

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	200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]	
Diagnostic testing	[0-50]%	[[0-50]%][Not Covered]
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits What the Policy Pays For" section for specific information about what services are covered)	Copay or Coinsurance applies for specific benefit provided	[[0-50]%][Not Covered]
[Mental, Emotional or Functional Nervous Disorders		
[Inpatient]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-50]%]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [Not Covered]
[Outpatient]	[$[0-250] [copay] [PCP][specialist Office Visit benefit applies] [per visit] [[0-50]%] [Deductible waived]	[[0-50]%] [Not Covered]]
[Substance Abuse		
[Inpatient Rehabilitation]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	[[$[500-5,000] Additional Deductible per admission, then] [0-50%] [Not Covered]
[Inpatient Detoxification [only]]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]	[$[500-5,000] Additional Deductible per admission, then] [[0-50]%] [Not Covered]
Outpatient	[$[0-250] [specialist Office Visit benefit applies] [per visit]	

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		[[0-50]%] [Not Covered]]
[Smoking Cessation]	[[0-50]%[Deductible waived]]	[[0-50]%[Deductible waived]] [All except $[50-500] per Year for any smoking cessation program] [and][All except $[50-500] per Year for any smoking-cessation related pharmaceuticals] [Deductible waived][Not Covered]
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility]**	[$[500-5,000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [0%-50]%	NOT APPLICABLE
[Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility)**]** [Travel benefit Lifetime maximum payment of $[10,000-800,000]]		NOT APPLICABLE
Other Cigna Network Facility	[$[500-5,000] Additional Deductible per admission, then][0-50]%] [$[250-2,000] Copayment per inpatient day [Limit of [3-10]days of inpatient copayments per year]][0-50%]]	NOT APPLICABLE
[Out-of-Network Facility]	NOT APPLICABLE	[$[500-5,000] Additional Deductible per admission, then] [0-50]%][Not Covered] [Subject to the following limits per transplant: Heart - $150,000 Liver - $230,000

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		Bone Marrow -$130,000 Heart/Lung - $185,000 Lung - $185,000 Pancreas - $50,000 Kidney - $80,000 Kidney/Pancreas – $80,000]
[Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-50]%	[[0-50]%][Not Covered]]
[Routine Adult Eye Exam [Limited to one routine eye exam [per Year][every 2 years]] [Limited to one pair of glasses or contact lenses [per Year][every [2-3] years]]	[Not Covered] [$[10-200 Copayment per exam] [0% up to a maximum of $[15-100] per exam] [0% up to a maximum of $[50-300] for frames, lenses and/or contact lenses]]	[[0-50]%] [Not Covered]]

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Prescription Drugs Benefits **[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.]** **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
[[Brand Name] Prescription Drug Deductible [does not apply to [Generic]Drugs]] [(Combined In and Out of Network)]	[$[100-5,000] [per Insured Person,] [per Calendar Year][Integrated medical and prescription drug Deductible]	
Cigna Retail Pharmacy Drug Program (Maximum [30-90]-day supply)	YOU PAY PER PRESCRIPTION OR REFILL:	YOU PAY PER PRESCRIPTION OR REFILL:
Preventive Drugs Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] [Brand Name] with no [Generic]alternative) [Other Preventive Drugs on the Cigna preventive drug list]	0% Deductible waived per Prescription or refill [0% [Deductible waived] per prescription or refill] [$[5-50]Copayment per prescription or refill]	[[0-50]% per Prescription or refill] [Not covered] [[0-50]%][Deductible waived] prescription or refill][Not Covered]
Generic drugs (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List] **[Generic drugs**- on the Prescription Drug List] **[Brand Name drugs designated as preferred (except as noted under Preventive Drugs)**[on the Prescription Drug List][with no Generic	[$[0-200] Copayment per prescription or refill][Up to a maximum of $[10-100] per prescription or refill]] [$[10-200] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost	[[0-50]% per Prescription or refill][$[0-200] Copayment per prescription or refill][Not Covered] [[0-50]% per Prescription or refill][$[10-400] Copayment per prescription or refill][Not

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equivalent]	of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]][Not Covered]	Covered]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred[on the Prescription Drug List]]	[$[20-300] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[40-500] per prescription or refill]][Not Covered]	[[0-50]% per Prescription or refill][$[20-600] Copayment per prescription or refill][Not Covered]
[**Self-administered injectables][and Specialty Medications]**	[$[50-400] Copayment per prescription or refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [covered under Mail order pharmacy only][Not Covered]	[[0-50]% per Prescription or refill] [$[50-800] Copayment per prescription or refill] [Not Covered] [covered under Mail order pharmacy only][Not Covered]
<u>Cigna Tel-Drug Mail Order Pharmacy Drug Program</u> **<u>(Maximum [90-100]-day supply)</u>** **Preventive Drugs** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] [Brand Name] with no [Generic]alternative) [Other Preventive Drugs on the Cigna preventive drug list]	0% Deductible waived per Prescription or refill [0% [Deductible waived] per prescription or refill] [$[15-125]Copayment per prescription or refill] [$[0-200] Copayment per prescription/refill]	[Not Available] [Not Available]

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	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Generic drugs (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List] **[Generic drugs**- on the Prescription Drug List]	[Up to a maximum of $[10-100] per prescription or refill]] [$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]][Not Covered]	[Not available]
[Brand Name drugs designated as preferred (except as noted under Preventive Drugs) [on the Prescription Drug List][with no Generic equivalent]]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [[Up to a maximum of $[40-500] per prescription or refill]][Not Covered]	[Not available]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred [on the Prescription Drug List]]	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]	[Not available]
[**Self-administered injectables][and Specialty Medications]]**		[Not available]]

NEW VARIABLE BENEFIT SCHEDULE FOR 5-TIER PHARMACY- OAP/HSP Version

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.] **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
[Prescription Drug Deductible [does not apply to [Tier [1][2]]Drugs]] [(Combined In and Out of Network)]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Cigna Pharmacy Retail Pharmacy Drug Program	**(Maximum [30-90]-day supply)** **[(Maximum [31-100]-day supply) for Maintenance Medications]**	
Tier 1: Retail Preferred Generic	[$[2-10] Copay per Prescription or refill] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 2: Retail Non-Preferred Generic	[$[10-15] Copay per Prescription or refill] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 3: Retail Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[[50]% per Prescription or refill][Not Covered]
Tier 4: Retail Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[[50]% per Prescription or refill][Not Covered]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy (see Mail Order Pharmacy benefits)]]**	[[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You pay 100% of Cigna's discounted cost	[[50]% per Prescription or refill][Not Covered]

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
	of the drug]]	
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	[[50]% per Prescription or refill][Not Covered]
Cigna Tel-Drug Mail Order Pharmacy Drug Program **(**	**Maximum [90-100]-day supply)** **[Maximum [30-100]-day supply for Specialty Medications]**	
Tier 1: Mail Order Preferred Generic	[$[2-10] Copay per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 2: Mail Order Non-Preferred Generic	[$[10-15] Copay per Prescription or refill]] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[Not available]
Tier 3: Mail Order Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[Not available]
Tier 4: Mail Order Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[Not available]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy](see Mail Order Pharmacy benefits)]**	[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill] [and [0-50]% per Maintenance Drug Prescription or refill]	[Not available]

[BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Mail Order Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	[Not available]]

[**BENEFIT SCHEDULE** [EPO/OAP-INN VERSION]

Following is the Plan Benefit Schedule. The Evidence of Coverage sets forth, in more detail, the rights and obligations of both You and your your Family Member(s), and the Plan. It is, therefore, important that all Insured Persons **READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY!**

Remember, services from Out-of-Network providers are not covered except for initial care to treat and stabilize an emergency medical condition. For additional details see "

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Medical Benefits	
[Annual]Plan Deductible[*] Individual Family [Please Note: Additional Deductibles may apply to specific benefits.]	**In-Network Deductible** $[0-25,000] $[0-50,000]
[Additional Deductibles] [Some services may require a deductible for that service, and be subject to the [Annual Plan Deductible. Refer to the following pages of this Benefit Schedule for benefits on specific services.]	[Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Co-insurance [The coinsurance level for specialty Physician inpatient/outpatient physician services will differ between CCN and Non-CCN designated specialist services. The term CignaCare Network (CCN) refers to a designation given to Participating Providers who meet independently-established criteria determining efficiency and quality.]	[0-40]%
[Primary Care Provider (PCP)]	[[0-50]% of Charges[after the Policy Deductible.]
[CCN-designated PCP]	[[0-50]% of Charges [after the Policy Deductible].]
[Specialist]	[[0-50%]of Charges [after the Policy Deductible].]
[CCN-designated specialist]	[[0-50%]of Charges [after the Policy Deductible].] [[0-50%]of Charges [after the Policy Deductible].]
[Other Covered Services]	
Out-of-Pocket Maximum	**In-Network Out-of-Pocket Maximum**
Individual	[$[0-30,000][$0][Not Applicable]
Family	[$[0-60,000][$0][Not Applicable]
[The following do not accumulate to the Out of Pocket Maximum: [Penalties] and Policy Maximums.]	

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** NOTE: Please refer to the section on Prior Authorization of inpatient and outpatient services [above]for more detailed information. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of your ID card or at www.mycigna.com under "View Medical Benefit Details".	**Your Provider must obtain approval** for inpatient admissions; **or Your provider may be assessed a penalty** for non-compliance. **Your Provider must obtain approval** for selected outpatient procedures and services; **or Your provider may be assessed a penalty** for non-compliance.
All Preventive Well Care Services Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details **[Note**: Voluntary sterilization for men is covered at the regular plan benefit level.]	0% Deductible waived
Pediatric Vision Care Care Performed by an Ophthalmologist or Optometrist for Insured Persons less than [19]years of age. *Please be aware that the Pediatric Vision network is different from the network of your medical benefits **Comprehensive Eye Exam and Refraction for Children** Limited to one exam per year **Eyeglasses and Lenses for Children** Single Vision, Lined Bifocal, Lined Trifocal, and Lenticular. [Limited to one pair per year] **Theraputic Contact Lenses for Children** Limited to one pair per year] **Note:** Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	[0-50%% per exam] Deductible waived [0-50% per pair] Deductible waived [0-50% per pair] Deductible waived
Hearing Aids for children through age 18 **Maximum one hearing aid every 3 years**	[[0-50]%]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Note: Services necessary to select, fit and adjust the hearing aid are included in the benefit.	
Physician Services [Primary Care Physician (PCP) services] [Services of a specialist[, with PCP Referral and/or Plan Authorization] **Office Visit** **[(including [allergy testing and treatment/injections][and][lab and x-ray tests][and surgery]done in the office)]** [Primary Care][Physician] [(PCP)] [Non-Cigna Care Designation (CCN) PCP] **[Primary Care Physician (PCP) with CCN designation]**	[(No Referral Required)] [(PCP Referral or Plan Authorization is [NOT]required)] [$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Specialist, (including consultant, referral and second opinion services)[, **with PCP Referral and/or Plan Authorization]**	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
[Specialist, (including consultant, referral and second opinion services) **with CCN designation** [, **with PCP Referral and/or Plan Authorization]]** **[Note**: if a Copayment applies for OB/GYN visits:. If Your doctor is listed as a PCP in the provider directory, You or Your Family Member will pay a PCP Copayment. If Your doctor is listed [with a Cigna Care Designation, You or Your Family Member will pay the CCN specialist copay. If your doctor is listed]as a [non-CCN]]specialist, You or Your Family Member will pay the [non-CCN]specialist Copayment.]	[[$[10-250] Copayment] [per office visit] [[0-50]%] [with Deductible waived]] [per office visit;] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
Physician Services, continued [**Surgery in Physician's office**] **Outpatient Professional Fees[for Surgery**][(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy **Inpatient Surgery, Anesthesia, [Radiation Therapy][, Chemotherapy]** **In-hospital visits** **[Allergy testing and treatment/injections]**	[[[0-40]%] [included in Office Visit copayment]] [Deductible waived] [[[0-40]%] [included in outpatient facility copayment]] [Deductible waived] [0-40]% [Deductible waived] [0-40]% [Deductible waived] [[0-40]%[[included in Office Visit copayment]] [Deductible waived]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Hospital Services	
Inpatient Hospital Services [Facility Charges]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]
[Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment]
Emergency Admissions [Facility Charges]	[$[500-5,000] Additional Deductible per admission, then][0-50%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]]
[Professional Charges]	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [Included in facility per-day copayment]
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	[$[500-2,500] Additional Deductible per [service][visit][admission] then][[0-50]%]. [$[500-2,000] Copayment per [service][visit][admission]].
Emergency Services [Emergency services from an Out-of-Network Provider are covered at the In-Network benefit level]	
Emergency Room	[[$[50-1500] [Copayment][Access Fee, waived if admitted]per visit [then]][[0-50]%]]
Ambulance [emergency transportation [to the nearest facility][capable of handling the emergency][only.]]	[0-40]%[for [Ground][or]Air][transport]
Urgent Care	[$[25-250] Copayment per visit] [then] [[0-50]%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	[0-50]% [MRI:] [MRA:] [PET:] [CT Scan:] [Nuclear Medicine:] [$[100-1,000] Copayment per scan]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
All Other Laboratory and Radiology Services Facility and interpretation charges Physician's Office Free-standing lab or x-ray facility Outpatient hospital lab or x-ray	[$[10-250] Copayment] [[0-50]%][Subject to PCP/specialist office visit benefit] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by Independent/Outpatient X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived] [[0-50]%] [Deductible waived] 0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by services provided in a Physician's office Outpatient X-Ray/Lab Facilities] [then] [00-50]%][After Deductible][Deductible waived] [[0-50]%] [0% up to a maximum plan payment of $[100-500] per Insured Person, Per Year combined with services provided by provided in a Physician's office/ Independent X-Ray/Lab Facilities] [then] [0-50]%][After Deductible][Deductible waived]
Short-Term Rehabilitative Services [Physical,] [Occupational,] [Speech,][and Chiropractic] [Therapy] [Acupuncture][/ Acupressure] [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per [day] [visit].]
Cardiac & Pulmonary Rehabilitation [Maximum of [25-60] visits] per Insured Person, per calendar year, per therapy] [Limits based on Medical Necessity guidelines]	[0-50]% [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except$[10-50] per [day] [visit].]
[[Acupuncture][/Acupressure] [Maximum of [10-40] visits per Insured Person, per calendar year for all therapies combined.]	[$[10-250]Copayment] [PCP][or][specialist]office visit benefit applies][per visit][day]] [[0-5]%] [All except [$10-$50] Per Insured Person, per visit.]
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	[[0-50]%] Copay or Coinsurance applies for specific benefit provided
Habilitative Services Including **[Physical,] [Occupational,] [Speech] [Therapy]** [Maximum of [10-40] visits per Insured Person, per calendar year, per therapy] **[Note**: Maximum does not apply to services for treatment of Autism Spectrum Disorders]	[[0-50]%] [$[10-250] Copayment] [[PCP][or][specialist office visit benefit applies][per visit] [All except $[10-50] Per Insured Person, per [day] [visit].]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Womens' Contraceptive Services, Family Planning and Sterilization	[$0] [No charge, no Deductible]
Male Sterilization	Copay or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery) /Complications of Pregnancy	[0-50]%
Initial Office Visit to confirm pregnancy [and subsequent prenatal visits billed separately from the "global" fee]	[$[10-200] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-250]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
Prenatal services, Postnatal and Delivery (billed as "global" fee)	[0-50]%
Hospital Delivery charges	[[$500-5000] Additional Deductible per admission, then][0-50]%
Prenatal testing or treatment billed separately from "global" fee	[0-50]% [Deductible waived]
Postnatal visit or treatment billed separately from "global" fee	[$[10-250] Copayment] [per office visit; [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%]
Dental Care (other than Pediatric) Limited to treatment for accidental injury to natural teeth within six months of the accidental injury Anesthesia for dental procedures for a child under age 8	[0-50]%
Treatment of Diabetes (Pharmaceuticals for monitoring or treatment of diabetes are covered under the prescription drug benefit)	[0-50]%

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Medical Services for Treatment of Phenylketonuria (PKU)	[0-50]%
Autism Spectrum Disorders [For Insured Persons [under age [2110 25 only]] 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) [Maximum of $[36,000-65,000] per year for Applied Behavioral Analysis treatment/therapy per Insured Person]	[PCP or Specialist Office Visit benefit applies][$[10-250] Copayment] [per office visit;] [[0-50]%] [Deductible waived]] [No charge after office visit copay if only x-ray and/or lab services are performed and billed.] [Visits [1-10] per Year : $[0-200]Copay] [all visits after the first [1-10] per Year: [0-50]%] [visits [2-10]-[3-15] per Year: [0-50]%] [visits over [5-15] per Year: [0-50]%] [0-50]% Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities [Including]Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities] [Maximum of [20-100] days per Insured Person per calendar year for all facilities listed]	$[500-5000] Additional Deductible per admission, then] [[0-50]%] [$[250-2,000] Copayment per inpatient day][Limit of [3-10 days of inpatient copayments per Year]
Home Health Services [Maximum [20- 100] [days] [visits] maximum per Insured Person, per calendar year.] [Maximum [4-16]hours per day] [Maximum [2-8] visits per day]	[0-50]%
Durable Medical Equipment	[0-50]%
Prosthetics	[0-50]%
Hospice Inpatient Outpatient	[[0-50]%][Inpatient Hospital Services benefit applies] [[0-50]%] [$[25-250]Copayment per [day][visit]] [Deductible waived]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
Dialysis Inpatient Outpatient	Inpatient Hospital Services benefit applies [$[500-2,500] Additional Deductible per [service][visit][admission] then] [[0-50]%] [$[500-2,000] Copayment per [service][visit][admission]]
[Mental, Emotional or Functional Nervous Disorders Inpatient Outpatient	[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] then] [0-50]%] [$[10-250]]copay][specialist Office Visit benefit applies] [per visit] [[0-50]%] [Deductible waived]
[Substance Abuse Inpatient Rehabilitation [Inpatient Detoxification [only]] Outpatient	[[$[500-5,000] Additional Deductible per admission, then][[0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [[$[500-5000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]] [$[10-250] copay][specialist Office Visit benefit applies][per visit]] [[0-50]%][Deductible waived]]
[Smoking Cessation] [	[0-50]%[Deductible waived]]
Organ and Tissue Transplants- (see benefit detail in "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.) **Cigna LIFESOURCE Transplant Network® Facility**	[$[500-5000] Additional Deductible per admission, then] [0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]]

BENEFIT INFORMATION Note: Covered Services are subject to [applicable][Annual][and any additional deductible(s)]unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna contract allowance) YOU PAY
[Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility)**]** [Travel benefit Lifetime maximum payment of $[300,000-800,000]] **Other Cigna Network Facility]**	$[10,000-20,000][0%-50]% [$[500-5000] Additional Deductible per admission, then][0-50]%] [$[250-2,000] Copayment per inpatient day[Limit of [3-10]days of inpatient copayments per Year]] [0-50%]]
[Infusion and Injectable Specialty Prescription Medications and related services or supplies	[0-50]%
[Routine Adult Eye Exam] [Limited to one routine eye exam [per Year][every 2 years]] [Limited to one pair of glasses or contact lenses [per Year][every [2-3] years]]	[Not Covered] [$[10-250 Copayment per exam] [0% up to a maximum of $[15-100] per exam] [0% up to a maximum of $[50-300] for frames, lenses and/or contact lenses]]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
Prescription Drugs Benefits **[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.]** **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
Days Supply	**(Maximum [30-90]-day supply)**	**Maximum [90-100]-day supply) [Maximum [30-100]-day supply for Specialty Medications]**
[[Brand Name] Prescription Drug Deductible [does not apply to [Generic] Drugs]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Preventive Drugs Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives that are: • Prescribed by a Physician • [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	0% Deductible waived per Prescription or refill
[Other Preventive Drugs on the Cigna preventive drug list]	[0% [Deductible waived] per prescription or refill] [$[5-50]Copayment per prescription or refill]	[0% [Deductible waived] per prescription or refill] [$[15-125]Copayment per prescription or refill]
Generic drugs (except as noted under Preventive Drugs) **[[Preferred Pharmacy]Generic drugs**- on the Prescription Drug List] **[Generic drugs**- on the Prescription Drug List]	[$[0-200] Copayment per prescription/refill] [Up to a maximum of $[10-100] per prescription or refill]]	[$[0-200] Copayment per prescription/refill] [Up to a maximum of $[10-100] per prescription or refill]]
[Brand Name drugs designated as preferred (except as noted under Preventive Drugs) [on the Prescription Drug List][with no Generic equivalent]]	[$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]]	[$[20-400] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[20-250] per prescription or refill]]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	[Not Covered]	[Not Covered]
[Brand Name drugs [with a Generic equivalent]and drugs designated as non-preferred[on the Prescription Drug List]]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [[Up to a maximum of $[40-500] per prescription or refill]] [Not Covered]	[$[50-600] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [[Up to a maximum of $[40-500] per prescription or refill]] [Not Covered]
[**Self-administered injectables][and Specialty Medications]** [on the Prescription Drug List]	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]	[$[100-900] Copayment per prescription/refill][Plus the difference between the cost of the prescription and/or refill and the cost of the Generic equivalent] [Up to a maximum of $[50-1,000] per prescription or refill]] [Not Covered]]
[Prescription Drug Coverage Notes:] • [Coverage includes pain management for terminally ill patients as stated in the Evidence of Coverage]]		

NEW VARIABLE BENEFIT SCHEDULE FOR 5-TIER PHARMACY ---- EPO/OAP-INN etc. PLANS

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
Prescription Drugs Benefits	**(Maximum [30-90]-day supply) [(Maximum [31-100]-day supply) for Maintenance Medications]**	**Maximum [90-100]-day supply) [Maximum [30-100]-day supply for Specialty Medications]**
[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.] **[In the event that You or Your Physician requests a more expensive "brand-name" drug where a "generic" drug would otherwise have been dispensed, you will be financially responsible for the difference between the cost of the "brand-name" drug and the cost of the "generic" drug, plus any required Copayment or Coinsurance indicated in the Benefit Schedule]** **[Covered in-network only]**		
[Prescription Drug Deductible [does not apply to [Tier [1][2]]Drugs]] [(Combined In and Out of Network)]	[$[100-2,000] [per Insured Person,] [per Calendar Year]	
Cigna Pharmacy Retail Pharmacy Drug Program		
Tier 1: Retail Preferred Generic	[$[2-10] Copay per Prescription or refill] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[$[2-10] Copay per Prescription or refill]] [and $[5-15] Copay per Maintenance Drug Prescription or refill][[0-50]%]
Tier 2: Retail Non-Preferred Generic	[$[10-15] Copay per Prescription or refill] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]	[$[10-15] Copay per Prescription or refill]] [and $[20-40] Copay per Maintenance Drug Prescription or refill][[0-50]%]
Tier 3: Retail Preferred Brand	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]	[$[40-60] Copay per Prescription or refill] [and $[120-150] Copay per Maintenance Drug Prescription or refill] [plus the difference between the cost of the brand name medication and the generic equivalent][[0-50]%]
Tier 4: Retail Non-Preferred Brand	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]	[0-50]% plus a $[60-80] Copay per Prescription or refill [and [0-50]% plus a $[150-200] Copay per Prescription or refill]
Tier 5: Specialty generic and brand name medications that meet criteria of specialty drugs **[Specialty Medications Must be filled through Mail Order Pharmacy[after the first [fill][1-3 fills] at a Retail Pharmacy (see Mail Order Pharmacy**	[[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill]] [and [0-50]% per Maintenance Drug Prescription or refill for the first [1-3] fills; [after the [1st-3rd fill at retail,] You	[0-50]% per Prescription or refill [and $[120-150] Copay per Maintenance Drug Prescription or refill] [and [0-50]% per Maintenance Drug Prescription or refill]

[PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY [Preferred Pharmacy and] Network Pharmacy] YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
benefits)]]	pay 100% of Cigna's discounted cost of the drug]]	
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including womens' contraceptives) that are: • Prescribed by a Physician [Generic] or [Brand Name] with no [Generic]alternative)	0% Deductible waived per Prescription or refill	0% Deductible waived per Prescription or refill]

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.

[**Access Fee** refers to the additional amount of Covered Expense which each Insured Person must pay for an emergency room visit that does not result in an admission to the Hospital. Any Access Fees owed are reflected in the Schedule of Benefits section of this Policy.]

[Additional Deductible means an additional amounts of Covered Expenses which the Insured Person must pay before any benefits are available for specific services (e.g., [Brand Name] Prescription Drug Pharmacy Deductible).]

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, generally beginning in October and ending in December, when individuals can apply for coverage under this Policy for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified][USE STATE-SPECIFIC DEFINITION IF YOU HAVE ONE]

Brand Name Prescription Drug (Brand Name) means a Prescription Drug that has been patented and is only produced by one manufacturer.

[**[Brand Name] Prescription Drug Deductible** means the Additional Deductible that each Insured Person must meet each Year before We will begin paying Covered Expenses for [Brand Name] Prescription Drugs. This Additional Deductible is separate from Deductibles that apply to medical services and does not accumulate toward satisfying the medical Out of Pocket Maximum[s].]

Cigna We, Our, and Us mean Cigna (Cigna Health and Life Insurance Company), or an affiliate. Cigna is a licensed and regulated insurance company operating throughout the United States.

[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.]**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include non-elective cesarean section, occurring during a period of gestation in which a viable birth is not possible, termination of ectopic pregnancy, and spontaneous termination of pregnancy. Complications of pregnancy do not include elective abortion, elective cesarean section, non-elective cesarean section when a viable birth is possible, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hypermesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

[Copayment/Copay is 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 and Reconstructive 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. 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". For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, 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 are listed in the benefit sections of this Policy and which are not specifically excluded by the Policy.

Creditable Coverage is coverage under any of the following: a self-funded or self-insured employee welfare benefit Policy that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001, et seq.); any group or individual health benefit Policy provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Policy offered under Chapter 89 of Title 5, United States Code; a public health Policy as defined by federal regulations, including coverage established or maintained by a foreign country; a health benefit Policy under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); Title XXI of the federal Social Security Act or state children's health insurance program.

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 activites 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.

Deductible means the amount of Covered Expenses each Insured Person must pay for Covered Services before benefits are available under this Policy. [Several types of deductibles may apply to this Policy and all are defined in this section.] [See the definitions for [Additional Deductible,][Individual In-Network Deductible,][, Family In-Network Deductible,][Individual Out-of-Network Deductible,][Family Out-of-Network Deductible][,] [[Brand Name] Prescription Drug Deductible].

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Diabetes Equipment is blood glucose monitors, including monitors designed to be used by blind persons; insulin pumps and associated appurtenances; to include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies. Podiatric appliances for the prevention of complications associated with diabetes. The repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during

the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

Diabetes 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.

Diabetes Pharmaceuticals & Supplies are test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, and glucagon emergency kits.

Effective Date is the date on which coverage under this Policy begins for You and any of Your Family Member(s).

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in

1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) serious impairment to bodily functions; or
3) serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Essential Health Benefits: To the extent covered under this plan, 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 Procedures means a drug, device or medical treatment or procedures is considered Experimental or Investigational 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 its is proposed; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or understudy to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis; or
- reliable evidence shows that the consensus of the 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 stated means of treatment of diagnosis.

Reliable evidence means only; the published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

[**Family Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Family In-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family In-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. There is no Individual Deductible when two or more Insured Persons are covered under this Policy. The Family In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for both medical and pharmacy services, that You must pay for You and Your Family Member(s) collectively before any benefits are available. Once the Family In-Network Deductible has been met all Insured Persons will begin to receive benefits under the Policy. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Family Out-of-Pocket Maximum:** Once the Family Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year. [Other Deductibles,][Pharmacy charges,][Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges]do not apply to the Family Out of Pocket Maximum and will always be paid by You. The Family Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Family In-Network Out-of-Pocket Maximum:** Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. [Deductibles,][Pharmacy charges,][Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges]do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family In-Network Out-of-Pocket Maximum:** applies if You have a family plan and You and one or more of Your Family Member(s) are insured under this Policy. Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out-of-Pocket Maximum and will always be paid by You. The Family In-Network Out-of-Pocket Maximum includes the Family In-Network Deductible, and is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Family In-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. 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-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Family Out-of-Network Deductible** applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this Policy. There is no Individual Deductible if You and one or more of your Family Member(s) are insured under this Policy.. The Family Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for [both] medical [and pharmacy] services, that You must pay for You and

your Family Member(s) collectively before any benefits are available. Once the Family Out-of-Network Deductible has been met all Insured Persons will begin to receive benefits under the Policy. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[The **Family Out-of-Network Out-of-Pocket Maximum:** Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. [Deductibles,][Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and]non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[The **Family Out-of-Network Out-of-Pocket Maximum:** applies if You have a family plan and You and one or more of Your Family Member(s) are insured under this Policy. Once the Family Out-of-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Non-Participating Providers, You and Your Family Member(s) will no longer be responsible to pay Coinsurance [and] [Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out of Pocket Maximum and will always be paid by You.The Family Out-of-Network Out-of-Pocket Maximum includes the Family Out-of-Network Deductible, and is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

Foreign Country Provider is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America.

Free-Standing Outpatient Surgical Facility
The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Generic Prescription Drug (or Generic) means a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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.

Hearing Aid is any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems.

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 any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations (d) a hospice facility, or (e) any other licensed facility or agency under a hospice care program.

Hospital is a facility that provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must:

- be licensed as a Hospital and operated pursuant to law; and
- be primarily engaged in providing or operating (either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- provide 24 hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- be an institution which maintains and operates a minimum of 5 beds; and
- have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
- maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, drug addicts, alcoholics and those primarily affording Custodial Care, educational care or those primarily affording care for mental and nervous disorders.

[**Individual Deductible** is the amount of Covered Expenses incurred for medical services that You must pay each Year before any benefits are available. The amount of the Individual Deductible is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Individual In-Network Deductible** is the amount of Covered Expenses incurred from Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual In-Network Deductible** applies if You have an individual plan and You are the only person Insured under this Policy. There is no Family Deductible if You are the only person insured under this Policy. The Individual In-Network Deductible is the amount of Covered Expenses incurred from Participating Providers, for both medical and pharmacy services, that You must pay each Year before any benefits are available. The amount of the Individual In-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Individual Out-of-Pocket Maximum:** Once the Individual Out-of-Pocket Maximum has been met for the Year, for Covered Services, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year. [Deductibles,] [Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges] do not apply to the Individual Out-of-Pocket Maximum and will always be paid by You. The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Coinsurance for Covered medical Services. The amount of the Individual Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(EPO/OAP-INN language)]]

[**Individual In-Network Out-of-Pocket Maximum:** Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. [Deductibles,] [Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and][non-compliance penalty charges] do not apply to the Individual In-Network Out-of-Pocket Maximum and will always be paid by You. The Individual In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Coinsurance for medical services incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual In-Network Out-of-Pocket Maximum:** applies if You have an individual plan and You are the only person insured under this Policy. Once the Individual In-Network Out-of-Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Individual In-Network Out of Pocket Maximum and will always be paid by You. The Individual In-Network Out of Pocket Maximum includes the Individual In-Network Deductible, and is an accumulation of Covered Expenses incurred from Participating Providers. The amount of the Individual In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY)]]

[**Individual Out-of-Network Deductible** is the amount of Covered Expenses incurred from Non-Participating Providers, for medical services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. **[**(OAP POLICY LANGUAGE)]

[**Individual Out-of-Network Deductible** applies if You have an individual plan and You are the only person Insured under this Policy. There is no Family Deductible if You are the only person insured under this Policy. The Individual Out-of-Network Deductible is the amount of Covered Expenses incurred from Non-Participating Providers, for both medical and pharmacy services, that You must pay each Year before any benefits are available. The amount of the Individual Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[**Individual Out-of-Network Out of Pocket Maximum:** Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. [Deductibles,][Pharmacy charges,] [Access Fees,][Copays,][charges for Infusion and Injectable Specialty Prescription Medications] [and]non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of Pocket-Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(OAP POLICY LANGUAGE)]]

[**Individual Out-of-Network Out-of-Pocket Maximum:** applies if You have an individual plan and You are the only person insured under this Policy. Once the Individual Out-of-Network Out-of-Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You will no longer have to pay any Coinsurance [or Pharmacy Copays] for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Individual Out-of-Network Out of Pocket Maximum and will always be paid by You. The Individual Out-of-Network Out-of-Pocket Maximum includes the Individual Out-of-Network Deductible, and is an accumulation of Covered Expenses incurred from Non-Participating Providers.. The amount of the Individual Out-of-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

Illness is a sickness, disease, or condition of an Insured Person.

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 Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or chronic conditions. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or precertification[and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication].

Injury means an accidental bodily injury.

In-Network Out of Pocket Maximum is the maximum amount of [Deductible,][, Copayment][and] Coinsurance each Individual or Family incurs in Covered Expenses from Participating Providers in a Year.

Insured/Policyholder means the has applicant who has applied for, been accepted for coverage, and who is named as the insured on the specifications page.

Insured Person means both You, the applicant, and all other Family Member(s) who are covered under this Policy.

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of;

- [The provider's normal charge for a similar service or supply; or]
- [A percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna[; or].]
- [A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.]

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary services or supplies are those that are determined to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized community.
- Not primarily for the convenience of any Insured Person, Physician, or another provider's.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - i) There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service 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.

Medicare The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental, Emotional or Functional Nervous Disorders are neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Negotiated Rate is 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 Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Policy at the time services are rendered. [Covered Expenses for Non-Participating Providers are based on Maximum Reimbursable Charges which may be less than actual billed charges. Non-Participating Providers can bill you for amounts exceeding Covered Expenses.][REMOVE FOR EPO/OAP- INN PLANS]

Office Visit means a visit by the Insured Person, who is the patient, to the office of a Physician during which one or more of only the following 3 specific services are provided:

- History (gathering of information on an Illness or Injury)
- Examination
- Medical Decision Making (the Physician's diagnosis and plan of treatment)

[This does not include other services (e.g. x-rays or lab services) even if performed on the same day.]

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and subacute facilities.

[Out-of-Network Out of Pocket Maximum is the maximum amount of [Deductible,][Copayment][and]Coinsurance each Individual or Family incurs in Covered Expenses from Non-Participating Providers in a Year.] [REMOVE FOR EPO/OAP-INN PLANS]

Participating Pharmacy is a retail Pharmacy with which Cigna has contracted to provide prescription services to Insured Persons[;][or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order prescription services to Insured Persons].

Participating Provider is a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to a particular Policy under which an Insured Person is covered. A Participating Provider may also be referred to in this Policy by type of Provider—for example, a Participating Hospital or Participating Physician.

Patient Protection and Affordable Care Act of 2010 (PPACA)
The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pediatric Vision Services means vision care examinations, and other services or treatment described in the "Pediatric Vision Services" section of this Policy provided to an Insured Person who is under age [19-20].

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Pharmacy is a retail Pharmacy [,][or a mail-order Pharmacy.].

Pharmacy & Therapeutics (P & T) Committee is a committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician is 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 attached to this Policy, and any amendments or endorsements to this document.

[Policy Year is [each 12-month period while this Policy is in effect that begins on the day Your coverage first became effective, if Your coverage was effective on the first day of a month, otherwise the first day of the month following the day Your coverage first became effective][defined as a 12-month period that begins on [12/31/2013][date].
Note: Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.]

Prescription Drug is

- a drug which has been approved by the Food and Drug Administration for safety and efficacy;
- certain drugs approved under the Drug Efficacy Study Implementation review; or
- drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order is the lawful Authorization for a Prescription Drug or Related Supply by a Physician or other Provider who is duly licensed to make such Authorization within the course of such Physician's professional practice or each authorized refill thereof.

[Preventive Drugs on the Cigna Preventive Drug List are drugs or medications when taken by an Insured Person who has developed risk factors for a disease or condition listed below prior to onset of the disease or condition, or to prevent the reoccurrence of the disease or condition from which an Insured Person has fully recovered:

- [hypertension]
- [high cholesterol]
- [diabetes]
- [asthma]
- [osteoporosis]
- [stroke]
- [prenatal nutrient deficiency]

For example, the treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute Cigna-designated preventive care.]

Primary Care Physician is a Physician:

- who is a general practitioner, internist, family practitioner or pediatrician; and
- who has been selected by the Insured Person to provide or arrange for medical care for the Insured Person.

Prior Authorization: Inpatient Hospital admissions and certain services, equipment and other facility admissions require authorization in advance by Cigna to be eligible for benefits. If You, Your Family Member or the Provider fail to obtain Prior Authorization when required to do so by this Policy, We may apply a penalty that will reduce Covered

Expenses for the unauthorized services. Please call Cigna at the number on Your ID card to assure that all Prior Authorization requirements are met.

[**Priority Review** is an FDA classification for drugs where significant improvement is expected compared to marketed products, in the treatment, diagnosis, or prevention of a disease.]

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. 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 any other health care practitioner acting within the scope of the practitioner's license.

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.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy Policy and spacers for use with oral inhalers.

Self-administered Injectable Drugs are injectable Drugs which are approved for self-administration by the Food and Drug Administration.

[**Service Area** is any place that is [within the state of [Tennessee.]][within the counties and/or zip code areas in the state of [Tennessee] that Cigna has designated as the Service Area for this Plan. For specific information regarding Your Service Area, please check [website] or call [xxx-xxx-xxxx].]

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 tuberculosis, mental diseases or disorders or custodial or educational care.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

[**Special Limits** are limits applied to certain Covered Expenses in the form of [an] [a] [Annual,] [Lifetime,] [per visit,] [per day,] [or] [per event] maximum. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits to the applicable Covered Expenses. The expenses you incur which exceed specific maximums described in this Policy will be Your responsibility. The Special Limits are described in the Benefit Schedule and in the section of this Policy titled "How The Policy Works"]

[**Specialty Medication** means medications which are used to treat an underlying disease which is considered to be rare and chronic, including but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Medications may include high cost medications as well as medications that may require special handling and close supervision when being administered.]

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

[Telemedicine Medical Services is a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology other than by telephone or facsimile.]

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.

You, Your, and Yourself is the Policyholder who has applied for, and been accepted for coverage, as an Insured under the Policy and is named as the Insured on the specification page.

Who Is Eligible For Coverage?

Conditions Of Eligibility

This Policy is for residents of the state of Tennessee. The Policyholder must notify Us of all changes that may affect any Insured Person's eligibility under this Policy.

You are eligible for coverage under this Policy when you have submitted a completed and signed application for coverage and have been accepted in writing by Us. Other Insured Persons may include the following Family Members:

- Your lawful spouse[or partner to a civil union].
- Your children who have not yet reached age [26-30].
- Your stepchildren who have not yet reached age [26-30].
- [Your [unmarried]grandchildren who have not yet reached age [19-30] if they are Your dependents for Federal Income Tax purposes at the time of application.]
- [Your own, [or] Your spouse's [or Your partner to a civil union's] unmarried children, regardless of age, enrolled prior to age [26-30], who are incapable of self support due to [medically certified]continuing [mental or physical]disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's [19-30]th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.]
- Your own, [or]Your spouse's [or Your partner to a civil union's] Newborn children are automatically covered for the first 31 days of life. To continue coverage for a Newborn, You must notify Cigna [in writing] within 31 days of the Newborn's date of birth that You wish to have the Newborn added as an Insured Family Member, and pay any additional premium required.
- [Your Newborn grandchild will be automatically covered for the first 31 days of life if this grandchild is Your dependent for Federal Income Tax purposes at the time of application. To continue coverage, You must notify Cigna within 31 days of the Newborn grandchild's date of birth that You wish to have the Newborn grandchild added as an Insured Family Member, and pay any additional premium required.]
- [An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of [the adopted child's placement for]adoption or initiation of a suit of adoption. To continue coverage, You must enroll the child as an Insured Family Member by notifying Cigna within 31 days after the date of [placement for]adoption or initiation of a suit of adoption, and paying any additional premium.]
- If a court has ordered an Insured 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, You must enroll the child as an Insured Family Member by notifying Cigna in writing within 31 days after the date of the court order and paying any additional premium.
- A minor child who is by court order in the custody of a guardian who is a resident of Tennessee and covered under this policy.

When Can I Apply?

Initial Open Enrollment Period

The Open Enrollment Period is a federally-specified period of time (generally beginning in October and ending in December) 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 Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependents[, and We must receive that application] during the Annual Open Enrollment Period. Your coverage under this Policy will then become effective upon the first day of the [Month][Year]following the end of the prior Year's Open Enrollment Period. If You do not apply to obtain or change coverage during the Open Enrollment Period, You will not be able to apply again until the following Year's Open Enrollment Period.

Special Enrollment Periods

A special enrollment period occurs when a person enrolled in a qualified health plan, as defined by the Patient Protection and Affordable Care Act of 2010 (PPACA), experiences a triggering event such as loss of coverage or addition of a dependent. If You are covered under a qualified health plan, and You experience one of the triggering events listed below, You can enroll for coverage during a special enrollment period instead of waiting for the next

Annual Open Enrollment Period. Triggering events for a special enrollment period**, if You purchased Your plan on a state exchange ("on exchange" plans**) are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move[(including a move outside the service area of the individual's current plan)]; or
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
- An eligible individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide.

Annual Open Enrollment Period. Triggering events for a special enrollment period, **if You did not purchase Your plan on a state exchange ("off-exchange plans")** are:

- An eligible individual, including a dependent, loses his or her minimum essential coverage; or
- An eligible individual gains a dependent by marriage, birth or adoption; 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 gains a dependent by marriage, birth or adoption; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent; or

- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state exchange, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the exchange. In such cases, the exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual adequately demonstrates to the Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to that person; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a qualified health plan. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new qualified health plans as a result of a permanent move[(including a move outside the service area of the individual's current plan)]; or

Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission as specified in 45 CFR 147.128.

The special enrollment period begins on the date the triggering event occurs, and ends on the 61st day following the triggering event. Persons who enroll during a special enrollment period will coverage effective dates determined as follows:

- For an application made between the first and the 15th day of any month, the effective date of coverage will be the first day of the following month;
- For an application made between the 16th and the last day of the month, the effective date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility

An individual **will not be entitled to enroll** as an Insured Person if:

- [The individual was previously enrolled under a plan offered or administered by Cigna, any direct or indirect affiliate of Cigna, and his or her enrollment was terminated for cause; or] *Remove text for Guarantee Issue HIPAA Policy's*
- The individual has unpaid financial obligations to Cigna or any direct or indirect affiliate of Cigna; or
- The individual was previously enrolled under a plan offered or administered by Cigna and his enrollment was subsequently declared null and void for misrepresentations or intentionally omitted information or health history[; or
- The individual is eligible for Medicare Part A and Part B, or Part B only, or Part D, or is eligible for any Medicare benefit Policy offered by Cigna, any direct or indirect affiliate of Cigna.]

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 Insured.
- For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;
- The date the Policy terminates;
- [When the Insured no longer lives in the Service Area.]

Remember, it is Your responsibility to notify Cigna immediately of any changes affecting You or any of Your Insured Family Member(s) eligibility for benefits under this Policy.

Continuation

If an Insured Person’s eligibility under this Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this Policy would otherwise terminate. Coverage will continue without evidence of insurability[.]

How The Policy Works

This section describes [Deductibles][Access Fees] and [Copayments][/][Coinsurance] and discusses steps the Insured Person should take to ensure that they receive the highest level of benefits available under this Policy. Please refer to the "Definitions" section of the Policy to understand the meaning of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred while covered under this Policy. An expense is incurred on the date the Insured Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Policy, some of which may limit benefits or result in benefits not being payable.

Either the Insured Person or the provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. See "General Provisions", "How to File a Claim for Benefits", for further information.

Benefit Schedule

The Benefit Schedule shows 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 in the case of initial treatment and Stabilization of a Medical Emergency, as indicated below under "Special Circumstances".][USE FOR EOP/OAP-INN PLANS ONLY]

Participating Hospitals, Participating Physicians and Other Participating Providers.

Covered Expenses for Participating Providers are based on Our Negotiated Rate. Participating Providers have agreed **NOT** to charge more than the Cigna Negotiated Rates for Covered Services. Participating Providers may charge the Insured Person for services that are not Covered Services under the Policy. In addition, Participating Providers will file claims with Us for the Insured Person, and will request Prior Authorization when it is required.

Be sure to check with the provider prior to an appointment to verify that the provider is currently contracted with Cigna.

[Non-Participating Hospitals, Non-Participating Physicians, and Other Non-Participating Providers.

Covered Expenses for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, or a Maximum Reimbursable Charge. These services may be subject to additional penalties and/or Deductibles.][REMOVE FOR EPO/OAP-IN PLANS]

Special Circumstances

Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule in certain circumstances as provided below **.**

Under this circumstance benefits will be provided as follows:

- **Hospital Emergency Services**
  Emergency services for an Emergency Medical Condition will be paid at the Participating Provider benefit schedule. Once the patient is stabilized and he/she can be transferred to a Participating Hospital, medical payment will be reduced to the Non-Participating Provider benefit schedule if the Insured Person is not transferred to a Participating Hospital as soon as his or her medical condition permits.

- **Physician or other provider Emergency Services**
  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **[Availability of Preferred Providers**
  Covered Expenses for the services of a Non-Participating Provider will be paid according to the Participating Provider benefit schedule when the services of a Participating Provider are unavailable within the Service Area. Refer to the 'Definitions' section of this Policy for a description of the Service Area.]

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. [All Additional Deductibles apply to only certain provider or service types.]Deductibles do not include any amounts in excess of Maximum Reimbursable Charges,[Coinsurance,][Prescription Drug Copays,][Access Fees][Copayments] any penalties, or expenses incurred in addition to Covered Expenses. Any expenses incurred in addition to Covered Expenses are never applied to any Deductible.

Deductibles will be applied in the order in which an Insured Persons claims are received and processed by Us, not necessarily in the order in which the Insured Person received the service or supply.

[If the Insured Person submits a claim for services which have a maximum payment limit and the Deductibles are not satisfied, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.]

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as specifically stated otherwise in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available.

- [If You cover other Family Member(s), 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 Family Deductible is required for the remainder of that Year.[(EPO/OAP-INN POLICY LANGUAGE)]]

- [If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.[(OAP POLICY LANGUAGE)]]
- [If You cover other Family Member(s), the Family In-Network Deductible will apply. Covered Expenses for You and your Family Member(s) will collectively accumulate until the Family In-Network Deductible has been satisfied. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

- [If the In-Network Deductible <u>is not met</u> in a given Year, Covered Expenses incurred from October through December and applied toward the In-Network Deductible for that Year will also be applied toward the In-Network Deductible for the next Year. If the In-Network Deductible <u>is satisfied</u> in a given Year, We will <u>not carryover</u> any amount applied toward that In-Network Deductible to the next Year's In-Network Deductible.]

[Out-of-Network Deductible[(remove this section from EPO/OAP-INN plans)]

The Out-of-Network Deductible is applied only to Covered Expenses incurred for services received from Non-Participating Providers. [If the Insured Person submits a claim for services which has a maximum payment limit and the Out-of-Network Deductible is not satisfied, We will only apply the allowed per visit, per day, or per event amount, whichever applies, toward the Out-of-Network Deductible.] Only Maximum Reimbursable Charges will be applied to the Out-of-Network Deductible. Please see Policy Details for how Maximum Reimbursable Charges are calculated.

- The Out-of-Network Deductible is stated in the Benefit Schedule. The Out-of-Network 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 Non-Participating Providers each Year before any benefits are available.

- [If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Each Insured Person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year. [(OAP POLICY LANGUAGE)]]
- [If You cover other Family Member(s), the Family Out-of-Network Deductible will apply. Covered Expenses for You and your Family Member(s) will collectively accumulate until the Family Out-of-Network Deductible has been satisfied. Once this Family Out-of-Network Deductible is satisfied, no further Family Out-of-Network Deductible is required for the remainder of that Year. [(HEALTH SAVINGS PLAN POLICY LANGUAGE)]]

[Additional Deductibles[and [Access Fees][Copayments]]

This benefit Policy may contain Additional Deductibles [and/or Access Fees]which are specific to certain benefits. Please see the Benefit Schedule for specific dollar amounts.

- [Emergency room services: An [**Additional**]**[Access Fee][Copayment]** per visit will apply[, unless the visit results in an inpatient admission into that Hospital immediately following the Emergency room visit].]
- [Inpatient Hospital stay: An additional Deductible will apply per admission.]
- [Pharmacy: An **Additional Deductible** per Year will apply for [Brand Name][Tier[s] [2][3][4][5]] Prescription Drugs. Each Insured Person must meet the Prescription Drug Deductible each Year before receiving benefits for [Brand Name] Tier[s] [2][3][4][5]] Formulary and Non-Formulary Prescription Drugs. This Deductible is separate from other benefits and does not accumulate toward satisfying any other Deductible. See the section entitled "Prescription Drug Benefits".]]]

Out of Pocket Maximum[s]

The Out of Pocket Maximums are the amount of Coinsurance, [Deductible, and Copayment each Insured Person incurs for Covered Expenses in a Year. The Out of Pocket Maximums **do not** include any amounts in excess of [Maximum Reimbursable Charges,]any penalties, or any amounts in excess of other benefit limits of this Policy.

- [Once an Insured Person reaches the Out of Pocket Maximum in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year.][(EPO/OAP-INN POLICY LANGUAGE)]

- [Once an Insured Person(s) reaches the Out of Pocket Maximum for either Participating or Non-Participating Providers in a Calendar Year, the Insured Person will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.]

- [If you cover other Family Member(s), each Insured Person's Covered Services accumulate toward the Family Out of Pocket Maximum. Once the Out of Pocket has been met, the Family will no longer have to pay any Coinsurance for Covered Expenses incurred during the remainder of that Year.][(EPO/OAP-INN POLICY LANGUAGE)]

- [If you cover other Family Members, the Family Out of Pocket Maximum will apply. The Out of Pocket Maximum is an accumulation of Covered Services for all Insured Persons for either Participating or Non-Participating Providers in a Year. Once the Out of Pocket has been met the Family will no longer have to pay any Coinsurance for Covered Expenses for the services of a Participating or Non-Participating Provider, whichever maximum has been met, for Covered Expenses incurred during the remainder of that Year.]

[Special Limits

Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on [Annual,] [Lifetime][or][payment][Maximums which may apply to]these specific Benefits.

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[s];
- Not eligible for benefit payment once the Deductible is satisfied, and
- Payable by the Insured Person.

[If the Insured Person submits a claim for services which have a maximum payment limit, We will only apply the allowed per visit, per day, or per event amount (whichever applies) toward Your penalty amount.]

Penalties will apply under the following circumstances:

- Inpatient Hospital admissions may be subject to a Penalty if You or Your Provider fail to obtain Prior Authorization.
- [Free Standing Outpatient Surgical Facility Services may be subject to a Penalty per admission, if You or Your Provider fail to obtain Prior Authorization.]
- [Certain outpatient surgeries and diagnostic procedures require Prior Authorization. If You or Your Provider fail to obtain Prior Authorization for such an outpatient surgery or diagnostic procedure, You or Your Provider may be responsible for a Penalty, per admission or per procedure.]
- [Authorization is required prior to certain other admissions and prior to receiving certain other services and procedures. Failure to obtain Authorization prior these admissions or to receiving these services or procedures may result in a Penalty.]

The Insured Person must satisfy any applicable penalty before benefits are available.]

Comprehensive Benefits: What the Policy Pays For

Please refer to the Benefit Schedule for additional benefit provisions which may apply to the information below.

Before this Participating Provider Policy pays for any benefits, You and Your Family Members must satisfy any Deductibles that may apply. After You fulfill the appropriate Deductibles, We will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Members receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, [Deductibles,][penalties,]exclusions, [Waivers]and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits 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 Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

For any eligible condition, this Policy provides indicated benefits on Covered Expenses for:

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- 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.

Services and Supplies Provided by a Skilled Nursing Facility

[To be eligible for maximum benefits, services of a Skilled Nursing Facility **must have Prior Authorization from Cigna before services are rendered** (See section titled "Prior Authorization Program").]
(**Please refer to Your Benefit Schedule for other benefit provisions which may apply.)**

For any eligible condition [that is Authorized by Cigna,]this Policy provides indicated benefits for Covered Expenses for:

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services is subject to **all** of the following conditions:

- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing 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.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.
- Skilled Nursing Facility admissions in excess of the maximum covered days per Year.

Hospice Services

[To be eligible for maximum benefits Hospice Care Services must have Prior Authorization **from Cigna before services are rendered** (See section entitled "Prior Authorization Program"). **]**
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

[In addition,]the Insured Person must be suffering from a Terminal Illness for which the prognosis of life expectancy is six months or less, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written treatment plan to Us every 30 days.

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. The provider must also be approved as a Hospice provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which the Policy is sold.

Professional and Other Services

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- 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 (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic Appliances and Devices, artificial limbs or eyes;
- internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- [Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification[and will only be covered when provided by an approved Participating Provider specifically designated to supply that specialty prescription medication].;]and
- Rental or purchase of medical equipment and/or supplies that meet all of the following requirements:
  - Ordered by a Physician;
  - Of no further use when medical need ends;
  - Usable only by the patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control;

- Not for exercise; and
- And manufactured specifically for medical use.

Note: Medical equipment and supplies must meet **all** of the above guidelines 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.

Cigna determines whether the item meets these conditions.

Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses incurred for the following ambulance services:

- Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital or Skilled Nursing Facility.
- Monitoring, electrocardiograms (EKGs or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.

[Ambulance transportation is covered for emergency situations only, to the nearest facility capable of handling the emergency.]

Services for Short Term Rehabilitative Therapy (Physical Therapy, Occupational Therapy[, Chiropractic][,and Speech Therapy][and] [Acupuncture/Acupressure])

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

The term ["visit"][“day”]includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, [manipulation of the spine,]or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury are payable up to the [combined maximum payment][and] [maximum number of [visits][days] as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for speech therapy, including services of a licensed audiologist, speech therapist or Physician for speech therapy. These services are payable up to the [combined maximum payment] [and] [number of [visits] [days] as stated in the Benefit Schedule.

All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the [visit][day] and will not be reimbursed in addition to the [visit] [day].

[Special Note:
Additional [visits][days] for Physical or Occupational Therapy may be covered following severe trauma such as:

- an inpatient hospitalization due to severe trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person’s impairment; and
- Cigna authorizes this in advance.**]**

Services for Cardiac Rehabilitation

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses incurred 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 is 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

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

The term ["visit"][“day”]includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Benefits for 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 are payable up to the [combined maximum payment][and][maximum number of [visits][days] as stated in the Benefit Schedule.

[Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech, payable up to the [combined maximum payment][and][number of [visits][days] as stated in the Benefit Schedule.]

All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the [visit][day] and will not be reimbursed in addition to the [visit][day].

[Special Note:
Additional [visits][days] for Habilitative Services may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person’s impairment. Cigna must authorize any such additional [visits][days] in advance of treatment being provided.

[Acupuncture[/Acupressure] Services

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

The term ["visit"][“day”]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][day] and will not be reimbursed in addition to the [visit][day].]

[Special Note:
Additional [visits][days] for Acupuncture treatment may be covered following severe trauma such as:

- an inpatient hospitalization due to severe injury or trauma, such as spinal Injury or stroke; and
- Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Insured Person’s impairment; and
- Cigna authorizes this in advance.]]

[Services for Mental, Emotional or Functional Nervous Disorders [and Substance Abuse]

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

In order to qualify for benefits, services for [Mental, Emotional or Functional Nervous Disorders,][,or][substance abuse]must meet the following conditions:

- Services must be for the treatment of [a Mental, Emotional or Functional Nervous Disorder,][,or][substance abuse]and medical complications of mental illness or mental retardation that can be improved by standard medical practice.
- The Insured Person must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital or a Physician.
- Services are covered only for the number of days or visits which are Medically Necessary to treat the Insured's condition.
- Inpatient services must be received in a Hospital or Day Care Center for inpatient treatment.**]**

Dental Care

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for dental care for an accidental Injury to natural teeth, subject to the following:

1. services must be received during the 6 months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible accidental Injury; and
3. damage to natural teeth due to chewing or biting is not considered an accidental Injury under this Policy.

Dental Procedures Performed on Minors in Hospitals

Benefits are payable for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital dental procedures performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office.

Pregnancy and Maternity Care

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

Your Participating Provider Plan provides pregnancy and post delivery care benefits for You and Your Family Members

All comprehensive benefits described in this Plan are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an Eligible Dependent as defined in 'Conditions of Eligibility' in the section of this Plan titled "Who is Eligible for Coverage?".

The mother and her newborn child shall be entitled 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. 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.

Complications of Pregnancy

Complications of Pregnancy are covered under this Policy as any other medical condition. See the section titled "Definitions" to understand the meaning of Complications of Pregnancy as it relates to this Policy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

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 not in excess of the above periods. However, We may provide benefits for a shorter stay if the attending provider (*e.g.*, the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

All Preventive Care Services [(birth and older)]

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams.
- Annual mammogram.
- [United States Preventive Services Task Force (USPSTF) for services rated "A" or "B",] [Advisory Committee on Immunization Practices (HRSA)] recommended wellness screening laboratory tests and procedures, and radiology procedures in connection with the examination.
- Routine Immunizations, including flu shots, tetanus shots, evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U. S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- 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/center/regulations/prevention/recommendations.html]]

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, employment, school or sports.

Genetic Testing

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

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.

[Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent of an Insured Person has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.][**use ONLY if plan covers infertility]**

[Genetic counseling is covered if an Insured Person is undergoing approved genetic testing, or if an Insured Person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.]

Hearing Aids

Hearding aids for children to age 18 are covered as specified in the Benefit Schedule.

[Autism Spectrum Disorders

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses for Insured Persons [under age][10-25]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:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

   Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. [COVER ONLY IF MANDATED, THIS LANGUAGE IS A PLACE-HOLDER]
3) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
   a) self care and feeding,
   b) pragmatic, receptive, and expressive language,
   c) cognitive functioning,
   d) applied behavior analysis, intervention, and modification,
   e) motor planning, and
   f) sensory processing.

Upon request from Cigna, a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.]

Organ and Tissue Transplants

[To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").]
(Please refer to the Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Hospital and professional services as described in the Policy for:

- An Insured Person who receives the organ or tissue.
- An Insured Person who donates the organ or tissue.
- An organ or tissue donor who is not an Insured Person, if the organ or tissue recipient is an Insured Person.

Benefits for the donor are payable only after benefits have been paid for the Insured Person's expenses, and then only to the extent benefits are available under the recipient's Policy.

Cigna has established a network of transplant facilities known as **Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities)** to provide services for specified organ and tissue transplants, including:

- heart
- liver
- lung
- heart/lung
- kidney
- simultaneous pancreas/kidney
- pancreas
- pancreas or intestine which includes small bowel-liver or multi-visceral
- bone marrow/stem cell harvest and transplant, including autologous and allogenic bone marrow/stem cell transplant

Note: A Participating Provider is not necessarily a Cigna LIFESOURCE Transplant Network® Facility.

[All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.] [(Remove for EPOPLANS/ USE FOR OAP-INN PLANS)]

Cornea transplants are **not** available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services, are payable at the In-Network level. [Transplant services received at any other facilities, including Non-Participating Providers [and Participating Providers contracted with Cigna for other services, but not for transplant services,]are [not covered] [covered at the Out-of-Network benefit level].] [(remove from '[Transplant services received at any other…. to end for EPO/OAP-INN PLANS)]][BLUE HIGHLIGHT USE FOR OAP-INN PER LANGUAGE FROM STATE FILINGS]

[The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following **travel expense benefits** that will be provided for:

- The recipient and 1 travel companion, when the recipient is an Insured Person.
- [The donor, if the recipient is an Insured Person.]

The travel expense benefit is provided in connection with a covered organ or tissue transplant **only** if Covered Services are provided by a designated Cigna LIFESOURCE Transplant Network® Facility. Transportation expenses, meals, and lodging expenses for the recipient and 1 companion [and a donor]will be paid **only** if there is not a qualified Cigna LIFESOURCE Transplant Network® Facility within 100 miles of the recipient's home. The recipient must utilize services at the closest qualified Cigna LIFESOURCE Transplant Network® Facility. All travel expenses must be Prior Authorized by Cigna.]

[Travel expenses for organ and tissue transplants are limited to a combined maximum reimbursement [of $[10,000-80,000] per lifetime,]as shown in the Plan Benefit Schedule.]

[Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

Benefits that are payable under this provision are subject to the following limitations:

- Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to the Cigna LIFESOURCE Transplant Network® Facility is limited to the amount equal to the cost of a round-trip coach airfare to the Facility.
- Transportation to the Cigna LIFESOURCE Transplant Network® Facility using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel and is limited to the cost of a round-trip coach airfare to the Facility.

- Hotel accommodations, daily meals and other reasonable and necessary services or supplies incurred by an Insured Person and a travel companion will be limited to $[100-500]per day.]

The following Organ and Tissue Transplants charges are excluded from payment under the Plan:

- Charges incurred prior to pre-transplant evaluation.
- Charges incurred for testing administered to people other than the living donor.
- Charges for any treatment, supply or device which is found by Cigna to be Experimental, Investigative or not a generally accepted medical practice.
- Charges for transplant of animal organs to a human recipient.
- Charges for mechanical devices designed to replace human organs, except for the use of a mechanical heart to keep a patient alive until a human donor heart becomes available, or a kidney dialysis machine.
- Charges incurred for keeping a donor alive for a transplant operation.
- Cigna LIFESOURCE Transplant Network® Facility charges for personal comfort or convenience items.

[**The following Organ and Tissue Transplant Travel Benefit charges are <u>excluded from payment under the Plan</u>:**

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.]

Treatment of Diabetes

Medical services for Diabetes are covered on the same basis as any other medical condition. This Policy provides benefits for Covered Expenses including outpatient Diabetes Self-Management Training and education, Diabetes Equipment and Diabetes Pharmaceuticals & Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

The following Diabetes Supplies are covered under the Prescription Drug Benefit:

Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.

Treatment Received from 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 does not accept assignment of benefits from Foreign Country Providers. You and Your Family Member can file a claim with Cigna for services and supplies from a Foreign Country Provider but any payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. The Insured Person at their expense is responsible for obtaining an English language translation of Foreign Country Provider claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, [Waivers,]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.

[Telehealth/Telemedicine Medical Services

Services for Telehealth/Telemedicine are covered under this Policy on the same basis as any other medical benefit. Please refer the the "Definitions" section of this Policy for a complete description of the services.]

Home Health Care

[To be eligible for maximum benefits, Prior Authorization for home health care must be obtained from Cigna before services are rendered. (See section titled "Prior Authorization Program").]
(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.
This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. [**Home Health services are limited to a 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 nonskilled care, custodial services 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 nonskilled care and/or custodial services needs. [Covered Services are limited to patient care that is determined to be Medically Necessary by Us. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of [6-8] visits per day, and prescribed by a Physician[in lieu of hospitalization].] Home Health Care Services must be provided by one of the following providers:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy, speech therapy and respiratory therapy.
- If the Insured is receiving the services of either of the above, the services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association also are covered. Such services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.
- Services of a medical social worker.

[Private duty nursing services are not covered, even if provided as part of a home health care treatment program.]

[Smoking Cessation

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses for any smoking cessation program designed to end the dependency on nicotine, [up to the maximum payment][as]shown in the Benefit Schedule.]

[Injury While Intoxicated or Under the Influence of a Narcotic]

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

This Policy provides benefits for Covered Expenses incurred as a result of and related to an injury sustained while an insured is either intoxicated or under the influence of a narcotic, regardless of the conditions under which the substance is administered by or under the advice of a Physician.]

Mastectomy and Related Procedures

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

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 lymphedema, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses.

Coverage for reconstructive breast surgery will not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of “Medically Necessary.” Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Treatment for Temporomandibular Joint Dysfunction (TMJ)

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)

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.

Phenylketonuria Treatment

Benefits are payable for charges for the treatment by licensed professional medical services under a Physician's supervision of phenylketonuria (PKU) including special dietary formulas which are Medically Necessary for therapeutic treatment. Special dietary formulas are covered under the Prescription Drug benefit.

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:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** as Covered Services in this Policy.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage under this Policy ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- [Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation, employer's liability law or occupational disease law,** even if the Insured Person does not claim those benefits.]
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (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].
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- [If the Insured Person is eligible for Medicare Part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.]
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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.
- Custodial Care.
- [[Inpatient][or][outpatient][services of a private duty nurse[, except as specifically stated under Home Health Care in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For"].]

- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- 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.
- 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.
- [Smoking cessation programs[, except as specifically provided in this Policy].]
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **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.
- **Hearing aids** for Insured Person's 19 and over, including but not limited to: semi-implantable hearing devices, audiant bone conductors, Bone Anchored Hearing Aids (BAHAs), batteries, cords and other assistive devices such as FM systems. [For the purposes of this exclusion, a hearing aid is any device that amplifies sound.]
- Routine **hearing tests** except as specifically provided under Preventive Care and Newborn Hearing Benefits.
- [Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.]
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy** [, expect as specifically stated in this Policy].]
- Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of [varicose veins;]abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. 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 lumpecctomy.
- [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].]
- [Non-Medical counseling or ancillary services, including but not limited to: [education,][training,][vocational rehabilitation,][behavioral training,][biofeedback,][neurofeedback,][hypnosis,][sleep therapy,][employment counseling, back school, return to work services, work hardening programs, driving safety,] [and services,][training,][educational therapy][or][other nonmedical ancillary services for learning disabilities and developmental delays].]
- [Services for redundant skin surgery, removal of skin tags, [acupressure,][acupuncture,]carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.]
- Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to **sex change**.

- Treatment of **sexual dysfunction** impotence and/or inadequacy[except if this is a result of an [Accidental Injury,][organic cause,][trauma,][infection,][or][congenital disease or anomalies]].
- [All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT)[, except as specifically stated in this Plan].]
- Cryopreservation of sperm or eggs or storage of sperm for artificial insemination (including donor fees).
- [All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription.]
- [Injectable drugs ("self-injectable medications) that do not require Physician supervision are covered under the Prescription Drug benefits of this Policy.]
- [All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy.]
- ♣ [Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy[, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription]. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.]
- ♣ **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- ♣ **Syringes**, except as stated in the Policy.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- **Blood administration for the purpose of general improvement in physical condition**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
- 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.
- **Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition,** including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **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.
- **Telephone, e-mail, and Internet consultations** or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters[, unless provided via an approved internet-based intermediary].
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **[Massage Therapy.]**
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.

- **Nutritional counseling** or food supplements, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, 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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **[[Growth Hormone Treatment[.]][**except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition.] [Growth hormone treatment]for [idiopathic short stature,][or] improved athletic performance is not covered under any circumstances.]]
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet[except as otherwise stated in this Policy].
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- Claims received by Cigna after [10-15] months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

[Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Copayment or Coinsurance shown in the Benefit Schedule, after You have satisfied any applicable [Brand Name][Prescription Drug][Plan]Deductible. Please refer to the Benefit Schedule for any applicable Copayments, Coinsurance, Deductibles or Maximums.] [OAP version]

[Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and, once the Deductible is satisfied, subject to any applicable [Copayments][and][or] [Coinsurance] shown in the Benefit Summary.]
[HSP version]

[When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for Your convenience, a Copayment will apply to each Prescription Drug.][**use with copay plans only**]

[When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for the Insured Person's convenience, a Copayment [and][or][Coinsurance]will apply to each Prescription Drug.]

[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-name"][“generic”] Copayment. shown in the Schedule.

[Your responsibility for covered Prescription Drugs and Related Supplies will always be the lowest of:

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription drug; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug.]

[Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers, regardless of the customer’s payment source.]

[[Brand Name] Prescription Drug Deductible

A [Brand Name]Prescription Drug Deductible must be satisfied by each Insured Person, each calendar year before We will pay for any Prescription Drugs or Related Supplies. This Additional Deductible is separate from Deductibles that apply to medical services.]

Covered Expenses

If the Insured Person(s), while covered under this Policy, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. [Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.] When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

What Is Covered

- [Generic] Outpatient Drugs and medications that Federal and/or applicable law restrict to sale by Prescription only.
- Insulin; syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs[except Insulin pens and cartridges].
- [Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.]

- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Special dietary formulas which are Medically Necessary for therapeutic treatment of Phenylketonuria (PKU) or other inheritable diseases
- [Contraceptive Drugs and devices approved by the FDA.]
- [Maintenance Drugs][and][Specialty Medications are covered.]

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing by a Physician, and subject to federal or state laws.
- Approved for use by the Food and Drug Administration.

- Approved for use by the Food and Drug Administration (FDA)[; or if prescribed for off-label use, charges made for or in connection with a Drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the FDA. Such Drug must be covered, provided:
  a. it is recognized as medically appropriate for the treatment of the specific type of condition for which the Drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal;
  b. it has been otherwise approved by the FDA; and
  c. its use for the specific type of treatment prescribed has not been contraindicated by the FDA
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail service program.
- 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 Specialty Prescription Medications may require prior authorization or precertification]

Exclusions

The following are not covered under the Prescription Drug Benefits. No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA).;
- drugs that do not require a federal legend (a federal designation for drugs requiring supervision of a Physician), other than insulin;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- [infertility drugs;]
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. 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.
- any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical

literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;

- ♣ prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- ♣ implantable contraceptive products inserted by the Physician are covered under the Plan's medical benefits;
- ♣ [Brand-Name drugs on the Prescription Drug List with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List;]
- ♣ [Drugs that are not on the Prescription Drug List]
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), herbal supplements and flouride, other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- [prescription smoking cessation products;]
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Growth Hormone Treatment [except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition;] [growth hormone treatment]for [idiopathic short stature,][or] improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Drugs and medications used to induce non-spontaneous abortions;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance, including anabolic steroids;
- 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;
- prescriptions more than one year from the original date of issue;
- [pre-filled insulin pens and cartridges]

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive [30-90]-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive [90-100]-day supply at a mail-order Pharmacy, unless limited by the drug manufacturer's packaging; or
- [up to a consecutive [30-100]-day supply for [the first fill]of Specialty Medications] [and][Self-Administered Injectable Drugs],at a Retail [Participating]Pharmacy unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive [30-100]-day supply for [the first fill]of Specialty Medications] [and][Self-Administered Injectable Drugs],at a home delivery [Participating]Pharmacy unless limited by the drug manufacturer's packaging; or]
- [up to a consecutive [90-102] day supply, [excluding][after][the first fill of][Specialty Medications] [and][Self-Administered Injectable Drugs], at a home delivery [Participating]Pharmacy, unless limited by the drug manufacturer's packaging; or]
- [limited to one fill of a Specialty Medication [or a Self-Administered Injectable Drug]at a retail [Participating]Pharmacy. If You exceed the one fill allowed at a retail [Participating]Pharmacy, You will be responsible for 100% of Cigna's discounted cost for the prescription.]
- [Infusion and Injectable Specialty Prescription Medications may require prior authorization or precertification.
- [Maintenance Drugs][and Specialty Medications][refills are covered at the retail pharmacy benefit level for the first [1-3]fills; any fills after the first [1-3]]are covered only through the Cigna Mail order pharmacy.]
- [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.]

[Coverage for Prescription Drugs and Related Supplies provided by a Participating Pharmacy is limited to those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List.]

[Coverage for Specialty Medications [and][Self-Administered Injectable Drugs] provided by a [Participating]retail Pharmacy is limited to the initial fill of each Prescription. After the initial fill at a retail Pharmacy those Prescriptions Drugs and Related Supplies that appear on the Prescription Drug List. Any subsequent fill of that Prescription must be made at a home delivery Pharmacy, or You will be responsible for 100% of Cigna's discounted cost for the prescription.]

[Coverage for Prescription Drugs and Related Supplies is limited to "generic" drugs unless a generic alternative does not exist or state law does not permit substitution.

[In the event that You or Your Physician requests 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-name"]["generic"] Copayment shown in the Schedule.]

[All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

[All newly approved drugs by the Food and Drug Administration (FDA) are designated as Non-Prescription Drug List drugs until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List. Prescription Drugs that represent an advance over available therapy according to the FDA

will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.]

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such sixth month period, all newly approved FDA drugs will be designated as either non-Preferred or non-Prescription Drug List drugs for the first sixth months of coverage until the P&T Committee evaluates the Prescription Drug clinically for a different designation.]

[Newly approved Food and Drug Administration (FDA) drugs are excluded from coverage for the first six months following FDA approval. However, those drugs that are classified by the FDA for Priority Review or granted an Orphan Designation will be covered immediately following their FDA approval. After such six month period all newly approved FDA drugs will be designated as Non-Prescription Drug List drugs for the first sixth months of coverage until the P & T Committee clinically evaluates the prescription drug and considers whether it may be placed on the Prescription Drug List.]

Pharmacy Formulary Exception Process/Prior Authorization – Coverage of New Drugs Pharmacy Formulary Exception Process/Prior Authorization

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. [Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.] If Your Physician believes non-Prescription Drug List Prescription Drug or Related Supplies are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to Cigna to request [a Prescription Drug List exception or]Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription.

If the request is approved, Your Physician will receive confirmation. The Prior Authorization will be processed in Our claim system to allow You to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

If the request is denied, Your Physician and You will be notified that coverage for the Prescription Drugs or Related Supplies was not authorized.

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If You have questions about specific Prescription Drug List exceptions or]a Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

Reimbursement/Filing a Claim

When an Insured Person purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. The Insured Person does not need to file a claim form.

If an Insured Person(s) purchases the Prescription Drugs or Related Supplies through a non-Participating Pharmacy, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see the mail-order drug introductory kit for details, or contact member services for assistance.

Claims and Customer Service

Drug claim forms are available upon written request to:

Cigna
P.O. Box 1019
Horsham PA 19044

1-800-TEL.DRUG
or
1-800-835-3784

If You or Your Family Members have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card.

[Pediatric Vision Benefits for Care Performed by an Ophthalmologist or Optometrist

Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit

Definitions

Pediatric Frame Collection means designated frames, that are adequate to hold lenses, and are covered in full under essential healthcare benefits.

Pediatric Vision Services means routine vision care examinations, preventive treatment and other services or treatment described in the "Pediatric Vision Services" section of this Policy provided to an Insured Person who is under age [0-20].

Pediatric Vision Benefits

Please be aware that the Pediatric Vision network is different from the network of your medical benefits.

Covered Pediatric Vision Benefits are subject to any applicable Coinsurance shown in the Benefit Schedule.

What's Covered

In-Network Covered Benefits for Insured Persons less than 19 years of age include:

- Examinations – One vision and eye health evaluation by an Optometrist or an Opthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses
  - Scratch-coating
  - Oversize lenses;
  - Solid and gradient tints.
- Frames – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.
- Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every 24months for an Insured with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the 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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What's Covered." within this section.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Prescription sunglasses.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Frames that are not in the designation Pediatric Frame Collection are not covered
- Elective contact lenses are not covered

Limitations

No payment will be made for more than one examination and one pair of lenses during a calendar year; or more than one pair of frames during a calendar year for any one person.

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye;
- lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
- care not listed in The Schedule;
- Other Exclusions and Limitations listed in this Policy

In addition, these benefits will be reduced so that the total payment under the items below will not be more than: 100% of the charge made for the vision service if the benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Cigna Vision Providers

To find a Cigna Vision Provider, or to get a claim form, the Insured Person should visit **myCigna.com** and use the link on the vision coverage page, or they may call Member Services using the toll-free number on their identification card.

Reimbursement/Filing a Claim

When an Insured Person(s) has an exam or purchases Materials from a Cigna Vision Provider they pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. The Insured Person does not need to file a claim form.

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision
Claims Department
PO Box 997561
Sacramento, CA 95899-7561

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

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.

Expenses For Which A Third Party May be Liable

If you incur a Covered Expense for which, in Our opinion, another party may be liable We shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for medical expenses and shall automatically have a lien upon the proceeds designated for medical expense of any recovery by judgement, settlement or award by you from such party to the extent of any benefits paid for such expenses under the Policy. You or your representative shall execute such documents as may be required to secure Our subrogation rights.

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.

Other Insurance

The Insured Person may have Other Valid Coverage (with another insurer) which applies to a loss covered by this Policy. Other Valid Coverage may reduce the benefits payable under this Policy. The benefits payable under this Policy will not be reduced by Other Valid Coverage if the Insured Person has notified Us in writing that they do have Other Valid Coverage. The Insured Person must notify Us before a loss begins. The benefits payable under this Policy will be reduced by Other Valid Coverage if the Insured Person has not notified Us in writing (before the loss begins) that the Insured Person does have Other Valid Coverage. The amount of he reduced benefits payable under this Policy will be determined by applying the formula below:

ADD: The benefit which would have been payable under this Policy,

PLUS: The total of the like benefits under all Other Valid Coverage's on the same loss of which We have had notice,

DIVIDED BY: The total like benefits under all valid coverage's for such loss.

When benefits are reduced due to Other Valid Coverage, We will return part of the last premium paid prior to the commencement of a loss covered under this Policy. The proportion We will use to determine the premium refund will be the same proportion We use to determine the benefit reduction in the formula above.

When Other Valid Coverage is written on a provision of service basis, the "like amount" of such other coverage will mean the dollar amount which the services received would have cost if the Insured Person did not have the other coverage.

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 received. That is why we have established a process for addressing 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, an initial eligibility denial, a rescission of coverage, or contractual benefits , you can call our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits, or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If an Insured Person is not satisfied with the results of a coverage decision, they can start the appeals procedure.

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing, within [180 days-365 days] of receipt of the denial notice, to the following address:

[Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422]

The Insured Person should state the reason why 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 the Benefit Identification card, explanation of benefits or claim form.

Requests for a 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 Necessity 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's Physician reviewer. The Insured Person may present his or her situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received the request within five working days after the date we receive the request for a Committee review and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. 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 and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

The Insured Person may request that the appeal process be expedited if, (a) 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 severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person’s medical condition.

Cigna’s Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours , followed up in writing.

If the Insured Person is not satisfied with Cigna’s decision regarding eligibility of an expedited external review, the Insured Person may file a complaint with the Commissioner’s office. The Commissioner may make a different

determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Independent Review Procedure

If the Insured Person is not fully satisfied with the decision of Cigna's appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a determination by Cigna regarding Medical Necessity, clinical appropriateness, healthcare setting, level of care, or effectiveness of the service or treatment the Insured Person requested. 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 - 180 days] of the Insured Person's receipt of Cigna's appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to the Insured Person's condition, as determined by Cigna's Physician reviewer, or if (b) the Insured Person's appeal concerns an admission, availability of care, continued stay, or health care item or service for which the Insured Person received emergency services, but the Insured Person has not yet been discharged from the facility, the review shall be completed within 72 hours.

If the Insured Person is not satisfied with Cigna's decision regarding eligibility for an expedited external review, the Insured Person may file a complaint with the Commissioner's office. The Commissioner may make a different determination regarding the Insured Person's eligibility for an expedited external review. The Commissioner's office may be contacted at the address and telephone number given below for an Appeal to the State of Tennessee.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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 Necessity, experimental treatment or other similar exclusion or limit; and (6) information about any office of health

insurance consumer assistance or ombudsman available to assis 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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy must be resolved in accordance with Our grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by Us that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Insured Person and Us will be acknowledged in writing, along with a description of how We propose to resolve the grievance.

[Binding Arbitration

To the extent permitted by law, any controversy between Cigna and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to binding arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the [Commercial Arbitration Rules of the American Health Lawyers Association], to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. [To the extent permitted by law,]the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.]

Terms of the Policy

Entire Contract; Changes: 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 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.

Grace Period: If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. There is a grace period of [10-31]days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period unless We notify the Insured Person at the billing address listed in Our records at least 30 days prior to any premium due date that We do not intend to renew this Policy, or the Insured Person notifies Us that the Insured Person intends for coverage to terminate. The grace period does not affect Our right to cancel or non-renew this Policy. Any premium due and unpaid may be deducted upon payment of a claim under this Policy.

Cancellation: We may cancel this Policy only in the event of any of the following:

1. You fail to pay Your premiums as they become due or by the end of the [10-31]day grace period.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception, or intentional misrepresentation of material fact in connection with this Policy or coverage.
5. When We cease to offer policies of this type to all individuals in your class, Tennessee 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 of a covered individual who may become eligible for the coverage.
6. When We cease offering any plans in the individual market in Tennessee, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. [When the Insured no longer lives in the Service Area.]

Any cancellation shall be without prejudice for any claim for Covered Expense 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.] [We will send written notice and the change will become effective on the next scheduled monthly or quarterly payment premium due date. This Individual Plan is renewable [Monthly or Quarterly][or][Annually], payment of the premiums will indicate acceptance of the change.]

[Member Services][Additional Programs]: We may, from time to time offer, or arrange for various entities to offer, discounts, benefits, or other consideration to You for the purpose of promoting Your general health and well being.]

Reinstatement: If this Policy cancels because You did not pay Your premium within the time granted You for payment, and if We, or an agent We have authorized to accept premium, then accepts a late premium payment from You without asking for an application for reinstatement, We will reinstate this Policy. [However, if We require an application for reinstatement, We will only reinstate this Policy if We approve Your reinstatement application. We will otherwise notify You in writing that We have disapproved Your reinstatement application.][However, if We require an application for reinstatement and give You a conditional receipt for Your late premium payment, We will only reinstate this Policy if either We approve Your reinstatement application, or lacking such approval, upon the forty-fifth day following the date on Our conditional receipt if We have not by that date notified You in writing of Our disapproval of Your application.]

If this Policy is reinstated, [benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement, or for an Illness that begins more than 10 days after the state of reinstatement. Otherwise,]You and Cigna shall have the same rights as existed under the Policy immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated Policy.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Certificate of Creditable Coverage: If coverage under this Policy terminates for any Insured Person, we will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. An Insured Person may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. To obtain a certificate call the toll-free customer service number on the back of your ID card. Such a certificate may help the Insured Person to obtain future coverage. However, Cigna is responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations, made by any other health insurance issuer with respect to any coverage it provides, including whether or not or to what extent the information contained in the certificate is relevant to the other health insurance issuer's actions.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. 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 identification card and on the Policy specification page.

- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.

- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

Cigna
Individual Services- Tennessee
P.O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

- When an overpayment has been made by US, WE will have the right within 18 months to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment. WE will have the right to recover an overpayment at any time if the insured does not provide complete information, was not eligible for coverage or when material mistakes or fraud have occurred.

- 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 Agreement 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. If We receive a claim from a Foreign Country Provider for a Medical Emergency, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.

- Any payment of benefits in reimbursement for Covered Expenses paid by an eligible child, or the eligible child's custodial parent or legal guardian, will be made to the eligible child, the eligible child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the eligible child.

- Cigna will provide written notice to You within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Cigna determines that You or Your Insured Family Members may be materially and adversely affected.

- Continuation of Care after Termination of a Provider whose participation has terminated:

  Cigna will provide benefits to You or Your Insured Family Members at the Participating Provider level for Covered Services of a terminated Provider for the following special circumstances:

  - Ongoing treatment of an Insured Person up to the 90th day from the date of the provider's termination date.
  - Ongoing treatment of an Insured Person who at the time of termination has been diagnosed with a terminal illness, but in no event beyond 9 months from the date of the provider's termination date.

- We will provide the Insured Person with an updated list of local Participating Providers when requested. If the Insured Person would like a more extensive directory, or need a new provider listing for any other reason, please call Cigna at the number on the ID card and We will provide the Insured Person with one, or visit our Web site, www.Cigna.com.

- If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect. However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

- Failure by Cigna to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

- If Insured Person(s) were **covered by a prior Individual Cigna Policy** that is replaced by this Policy with no lapse of coverage:

  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - If a Waiver was applied to the prior Policy, it will also apply to this Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

If while covered under this Policy, the Insured Person(s) is also covered by another Cigna individual or group Policy, the Insured Person(s) will be entitled to the benefits of only one Policy. Insured Person(s) may choose this Policy or the Policy under which Insured Person(s) will be covered. Cigna will then refund any premium received under the other Policy covering the time period both policies were in effect.

However, any claims payments made by Us under the Policy You elect to cancel will be deducted from any such refund of premium.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical Policy does not require that the Insured Person selects a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available under this medical Policy. Notwithstanding, a Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, We encourage the use of Primary Care Physicians and provide the opportunity to select a Primary Care Physician from a list provided by Cigna for each Insured Person. If the Insured person chooses to select a Primary Care Physician, the Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of your Family Members.

Changing Primary Care Physicians:

The Insured Person may request a transfer from one Primary Care Physician to another by contacting Us at the member services number on ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.
In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, The Insured Person will be notified for the purpose of selecting a new Primary Care Physician, if they choose.

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 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.

Unpaid Premiums: At the time of payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted from the payment.

Claim Forms: You may get the required claim forms from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on Your identification card.

Claim Reminders:

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL YOUR Cigna CLAIM OFFICE.
  - YOUR MEMBER ID IS SHOWN ON YOUR ID CARD.
  - YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR ID CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM.

Proof of Loss: You must give Us written proof of loss within 18 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 will not be liable for benefits if it does not receive written proof of loss within this time period.

Assignment of Claim Payments:

Medical Benefits are assignable to the provider; when you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. If payment is made to the Insured Person for services provided by a Non-Participating Provider, the Insured Person is responsible for paying the Non-Participating Provider and Our payment to the Insured Person will be considered fulfillment of Our obligation

We will recognize any assignment made under the Policy, if:

1. It is duly executed on a form acceptable to Us; and
2. a copy is on file with Us; and
3. it is made by a provider licensed and practicing within the United States.

We assume no responsibility for the validity or effect of an assignment.

Time Payment of Claims: All claims and indemnities payable under the terms of this Policy shall be paid immediately following written receipt by Us of due proof of loss.

[Payment of Claims: We may pay all or a portion of any indemnities provided for health care services to the participating health care services provider, unless You direct otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services provider directly to You, unless You direct otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular health care services provider. In the event of Your death, We will issue any benefits payable to You to the beneficiary of Your estate. In the absence of a valid release, We may pay up to $2000 to someone whom We deem entitled.]

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 preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice 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.

Preservice Medical Necessity Determinations

When the Insured Person or their representative requests a required Medical Necessity determination prior to care, Cigna will notify the Insured Person or their representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 15 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify the Insured Person or their representative within 24 hours after receiving the request to specify what information is needed. The Insured person or their representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify the Insured Person or their representative of the expedited benefit determination within 48 hours after the Insured Person or their representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the Insured Person or their representative fails to follow Cigna's procedures for requesting a required preservice medical necessity determination, Cigna will notify them of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the Insured Person or their representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for an Insured Person and they wish to extend the approval, the Insured Person or their representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the Insured Person or their representative requests such a determination, Cigna will notify them of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When an Insured Person or their representative requests a Medical Necessity determination after services have been rendered, Cigna will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

Postservice Claim Determinations

When an Insured Person or their representative requests payment for services which have been rendered, Cigna will notify them of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date the Insured Person or their representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Physical Examination and Autopsy: Cigna, at its own expense, shall have the right and the opportunity to examine any Insured Person for whom a claim is made, when and so often as We may reasonably require during the pendency of a claim under this Policy. In the case of death of an Insured Person, Cigna shall have the right and opportunity to make an autopsy where it is not prohibited by law.

Premiums

The monthly premium amount is listed on the Policy specification page which was sent with this Policy. This monthly premium amount applies to individuals whose monthly payment is deducted directly from their checking account. If You pay quarterly, the quarterly premium amount due is 3 times the monthly premium.

[You will be responsible for an additional [$][5-50]charge for any check or electronic funds transfer that is returned to Us unpaid.]

If You purchased Your Plan from a state exchange and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period , Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement. Otherwise, if You do not meet the criteria above, there is a grace period of [10-31]days for the receipt at our office there is a grace period of [10-31]days for the receipt at Our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see “General Provisions,” for further information regarding cancellation and reinstatement.

Your premium may change from time to time due to (but not limited to):

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any member which results in a higher premium
c. A change in residence

These changes will be effective on the first of the month following the change, unless as otherwise stated on Your premium notice.

Cigna also reserves the right to change the premium on 30 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.

CIGNA HealthCare
PO Box 30365
Tampa FL 33630-3365

Policy Specification Page

[Policy Name]
Benefit Option Code: [XXXX]

Insured:	[First, Last]		
Identification Number:	[XXXXXXXXX]	Policy Effective Date:	[mm/dd/yyyy]
Form Number:	**INDTNCH042013**	Plan Number	[XXXXXX]
Benefit Option Code:	[XXXX]	Annual Deductible	[$XXX]

This Policy Specification Page is part of and incorporated into the Policy identified by the Identification Number and Form Number shown above.

[This Policy is generally subject to a preexisting condition exclusion that runs 12 months from the effective date. This exclusion period may be reduced by qualified creditable coverage from your prior health plan. Listed below for each Insured Person is the preexisting Condition End Date as determined from the information we may have received regarding your creditable coverage.

If you disagree with the amount of coverage with which you are being credited, please submit an additional evidence of creditable coverage to CIGNA at the above listed address.]

INSURED PERSON(S) UNDER THIS PLAN

Name	Original Effective Date	Preexisting Condition End Date	Monthly Premium
[xxxxxxxxxxxxxxxx]	[xxxxxxxxxxxxxxxxx]	[xxxxxxxxxxxx]	[xxxxxxxxxxx]

Signed for CIGNA by:

Shermona Mapp, Corporate Secretary

[SUBSCRIBER NAME]
[ADDRESS]
[CITY STATE ZIPCODE] [BENEFIT OPTION CODE]

Bank Little Tunstead LB-A								

NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	48	28-Feb	28-Feb
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	49	01-Mar	01-Mar
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	50	02-Mar	02-Mar
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	51	03-Mar	03-Mar
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	52	04-Mar	04-Mar
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	53	05-Mar	05-Mar
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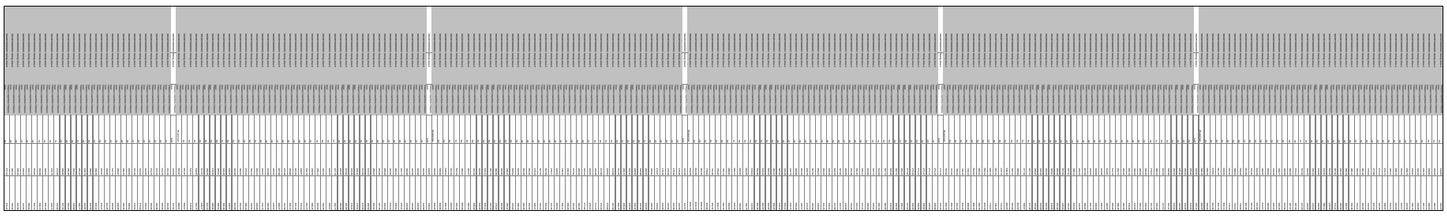
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	181	11-Jul	11-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	182	12-Jul	12-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	183	13-Jul	13-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	184	14-Jul	14-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	185	15-Jul	15-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	186	16-Jul	16-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	187	17-Jul	17-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	188	18-Jul	18-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	189	19-Jul	19-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	190	20-Jul	20-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	191	21-Jul	21-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	192	22-Jul	22-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	193	23-Jul	23-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	194	24-Jul	24-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	195	25-Jul	25-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	196	26-Jul	26-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	197	27-Jul	27-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	198	28-Jul	28-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	199	29-Jul	29-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	200	30-Jul	30-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	201	31-Jul	31-Jul
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	202	01-Aug	01-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	203	02-Aug	02-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	204	03-Aug	03-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	205	04-Aug	04-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	206	05-Aug	05-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	207	06-Aug	06-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	208	07-Aug	07-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	209	08-Aug	08-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	210	09-Aug	09-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	211	10-Aug	10-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	212	11-Aug	11-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	213	12-Aug	12-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	214	13-Aug	13-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	215	14-Aug	14-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	216	15-Aug	15-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	217	16-Aug	16-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	218	17-Aug	17-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	219	18-Aug	18-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	220	19-Aug	19-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	221	20-Aug	20-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	222	21-Aug	21-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	223	22-Aug	22-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	224	23-Aug	23-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	225	24-Aug	24-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	226	25-Aug	25-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	227	26-Aug	26-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	228	27-Aug	27-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	229	28-Aug	28-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	230	29-Aug	29-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	231	30-Aug	30-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	232	31-Aug	31-Aug
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	233	01-Sep	01-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	234	02-Sep	02-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	235	03-Sep	03-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	236	04-Sep	04-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	237	05-Sep	05-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	238	06-Sep	06-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	239	07-Sep	07-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	240	08-Sep	08-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	241	09-Sep	09-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	242	10-Sep	10-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	243	11-Sep	11-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	244	12-Sep	12-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	245	13-Sep	13-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	246	14-Sep	14-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	247	15-Sep	15-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	248	16-Sep	16-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	249	17-Sep	17-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	250	18-Sep	18-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	251	19-Sep	19-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	252	20-Sep	20-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	253	21-Sep	21-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	254	22-Sep	22-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	255	23-Sep	23-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	256	24-Sep	24-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	257	25-Sep	25-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	258	26-Sep	26-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	259	27-Sep	27-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	260	28-Sep	28-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	261	29-Sep	29-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	262	30-Sep	30-Sep
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	263	01-Oct	01-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	264	02-Oct	02-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	265	03-Oct	03-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	266	04-Oct	04-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	267	05-Oct	05-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	268	06-Oct	06-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	269	07-Oct	07-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	270	08-Oct	08-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	271	09-Oct	09-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	272	10-Oct	10-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	273	11-Oct	11-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	274	12-Oct	12-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	275	13-Oct	13-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	276	14-Oct	14-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	277	15-Oct	15-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	278	16-Oct	16-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	279	17-Oct	17-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	280	18-Oct	18-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	281	19-Oct	19-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	282	20-Oct	20-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	283	21-Oct	21-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	284	22-Oct	22-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	285	23-Oct	23-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	286	24-Oct	24-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	287	25-Oct	25-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	288	26-Oct	26-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	289	27-Oct	27-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	290	28-Oct	28-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	291	29-Oct	29-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	292	30-Oct	30-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	293	31-Oct	31-Oct
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	294	01-Nov	01-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	295	02-Nov	02-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	296	03-Nov	03-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	297	04-Nov	04-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	298	05-Nov	05-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	299	06-Nov	06-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	300	07-Nov	07-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	301	08-Nov	08-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	302	09-Nov	09-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	303	10-Nov	10-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	304	11-Nov	11-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	305	12-Nov	12-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	306	13-Nov	13-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	307	14-Nov	14-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	308	15-Nov	15-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	309	16-Nov	16-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	310	17-Nov	17-Nov
NEW/OTHER/REG. Delhi Metro 2	Delhi	Delhi Capital Metro Station	311	18-Nov	18-Nov



00:00:00.000000	Delay Alert 2	Total	0	00:00:00	00:00:00
		Total Capacity Impacting	0		

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

myCigna Health Savings 6100

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,100.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☐	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.2%
Metal Tier:	Bronze

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

myCigna Health Flex 5500

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,500.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	60.8%	**60.3% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Bronze	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Savings 3400

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,400.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Savings 3400 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,600.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.2%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Savings 3400 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.6%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Savings 3400 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$350.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$2,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.3%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Flex 1500

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.48	☑	☑		
Preferred Brand Drugs	☐	☐		$58.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.	
Actuarial Value:	69.1%	**69.1% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Silver	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Flex 1500 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$15.48	☑	☑		
Preferred Brand Drugs	☐	☐		$58.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.	
Actuarial Value:	72.6%	**72.5% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Silver	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Flex 1500 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$725.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$1,400.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.	
Actuarial Value:	86.3%	**86.3% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Gold	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Flex 1500 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$200.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$575.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$8.23	☑	☑		
Preferred Brand Drugs	☐	☐		$19.33	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.	
Actuarial Value:	93.5%	**93.4% --> Use this value because plan has limited Specialist OV**
Metal Tier:	Platinum	

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

myCigna Health Flex 5000

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$5,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	69.4%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

myCigna Health Flex 5000 73%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$4,250.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,250.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.0%
Metal Tier:	Silver

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

myCigna Health Flex 5000 87%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,450.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$1,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.2%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

myCigna Health Flex 5000 94%

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$600.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☐	☐		$60.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$8.23	☑	☑		
Preferred Brand Drugs	☐	☐		$19.33	☑	☑		
Non-Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

myCigna Health Savings 1900

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,900.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,350.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$0.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$0.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$0.00	☑	☑		
Specialist Visit	☑	☐		$0.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☐		$0.00	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑		
Rehabilitative Speech Therapy	☑	☐		$0.00	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☐		$0.00	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑		
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑		
Skilled Nursing Facility	☑	☐		$0.00	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☐			☑	☑		
Drugs	☑ All	☐ All			☑ All	☑ All		
Generics	☑	☐		$0.00	☑	☑		
Preferred Brand Drugs	☑	☐		$0.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☐		$0.00	☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.6%
Metal Tier:	Gold

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

myCigna Health Flex 1250

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$2,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☐ All	☐ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☐	☐		$40.00	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%		☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☐ All	☐ All			☑ All	☑ All		
Generics	☐	☐		$11.86	☑	☑		
Preferred Brand Drugs	☐	☐		$43.50	☑	☑		
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	67%		☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:	☐
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	☐
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	☐

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.6%
Metal Tier:	Gold

1. GENERAL INFORMATION

Insurance Company Name	Cigna Health & Life Insurance Company
NAIC Company Code	67369
HIOS Issuer ID	99248
State	Tennessee
Market Type	Individual
Proposed Effective Date	01/01/2014
Primary Contact Person and Title	Lauren Danziger, FSA, MAAA, Actuarial Manager
Primary Contact Telephone Number	(860) 226-6586
Primary Contact Email	Lauren.Danziger@Cigna.com

Scope and Purpose of Filing: Cigna Health & Life Insurance Company (CHLIC) is filing rates for comprehensive major medical products for individuals & families to be effective January 1, 2014. The plans represented in this filing will be Guaranteed Issue & Guaranteed Renewable and are to be marketed through brokers, general agents, and directly to consumers as described in the policy form. These plans are attached to a new product that has been submitted under policy form filing INDTNCH042013. This policy form is not subject to medical underwriting. Please note that the content of this filing is intended to be reviewed by an actuary.

CHLIC is the Cigna Company that is applying for certification as a Qualified Health Plan. Until recently, Cigna conducted its group and individual health insurance business through Connecticut General Life Insurance Company (CGLIC). Several years ago (pre-PPACA), Cigna made the business decision to cease writing insurance coverage through CGLIC and to migrate all existing and new business to CHLIC, which is a subsidiary of CGLIC. The timing of the migration of all health insurance business to CHLIC, by coincidence, results in CHLIC being used exclusively for new business in 2014. Accordingly, CHLIC is the Cigna Company that is applying for certification as a Qualified Health Plan.

2. PROPOSED RATE INCREASE

This will be the first year that individual health insurance coverage will be offered by CHLIC in this state. Since this is a filing for a new product, there is no rate increase associated with this filing. Consequently, the rates for the proposed plans in this filing should not be considered a rate increase or decrease because there is no current membership for CHLIC.

3. EXPERIENCE PERIOD PREMIUM & CLAIMS

As mentioned above, since this will be the first year that individual coverage will be offered by this company in this state, there is no experience to report in Section 1, Worksheet 1, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience, but they will show in the URR template and will cause cells V45 and V46 on Worksheet 1 and row 27 on Worksheet 2 of the template to indicate a rate increase over the experience period, but these values have only populated due to the minimal values referenced above. Similarly, Sections 2 and 3 of Worksheet 2 have been populated with minimal values and row 46 is reflecting an average 2014 rate instead of an average 'current' rate in order for the formulas to work properly in the template.

a. Paid Through Date: N/A
b. Premiums (Net of MLR): N/A
c. Allowed & Incurred Claims: N/A

4. BENEFIT CATEGORIES

To determine benefit categories, CHLIC uses a combination of Procedure Code and Place of Service to categorize each claim under an appropriate Major Service Category. These categories are defined as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, & other professional services, except hospital based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Prescription Drug: Includes drugs dispensed by a pharmacy, net of rebates received from drug manufacturers.

As mentioned earlier, since CHLIC currently does not have any business in the Individual Market in Tennessee, there is no experience data available for the company. Hence, no experience is shown for Worksheet 1, Section 2, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience.

5. PROJECTION FACTORS

Since CHLIC currently does not have any business in the Individual Market in Tennessee, there is no experience data or projection factors shown for the experience period in Worksheet 1, Section 2, of the Part 1 URR Template. Please note that minimal values have been entered in this section of the template to allow for the URR Template to successfully validate. These figures do not represent CHLIC's experience data or projection factors.

6. CREDIBILITY MANUAL RATE DEVELOPMENT

a. Source & Appropriateness of Experience Data used in Developing the Manual Rate

The source data used to generate the Manual Rate is trended national group experience adjusted for state and market specific differences. The experience for the national group book of business is deemed appropriate to be used for development of the Manual Rate because the baseline experience was not subject to individual medical underwriting and the benefits for the group experience are more similar to the benefits required to be ACA compliant than any other experience available. We address the adjustments to the baseline data below.

b. Adjustments made to the Data

The following adjustments were made during development of the Manual Rate to account for differences between the source data and characteristics of the anticipated population in the Individual Market for the proposed period:

- Morbidity Load – A 5% load was added to the Manual Rate to account for the difference in morbidity risk of the population underlying the Manual Rate and the anticipated population of the Individual Market in 2014. The morbidity load is in consideration of the following components:
    - The influx of members from high-risk pools, HIPAA, and conversion policies into the Individual Market. These types of plans are already guarantee issue, but morbidity factors are currently permitted for these specific plans compared with the rest of the individual market. Since all plans will be based on a single risk pool in 2014, the overall index rate has been developed with the anticipation that current policyholders in the afore-mentioned pools, are expected to enter or remain in the individual market and enroll on the new ACA compliant plans.
    - The influx of new entrants who were previously uninsured. According to the SOA sponsored study "Cost of the Future Newly Insured under the ACA", individuals who are currently uninsured have different average morbidity risk than the current individual market. As these uninsured enter the individual market in 2014, morbidity risk is expected to change.
    - Plan selection – Since all individuals will be part of a single risk pool in 2014 with no medical underwriting, it is expected that individuals with higher morbidity will select plans that will best meet their needs (i.e. plans with lower member cost share). To account for the impact of this selection, the overall index rate has been adjusted to reflect the increased utilization that stems from the selection of plans with lower cost share for individuals with higher

morbidity risk. This adjustment is applied to the index rate only and no plan-specific adjustments are being made to account for anticipated differences in health status of enrollees across plans.

- Pent-up demand – newly insured individuals in 2014 are anticipated to have a higher consumption rate of services as they hold off on medical services prior to being insured. While this increase in utilization is anticipated to be minimal overall, it is still expected to increase the average utilization rate for the individual market in 2014.
- The underlying experience data is based on a population of both non-smokers and smokers, so the experience has been adjusted to be reflective of a non-smoking population. The index rate is appropriate for a non-tobacco user. Tobacco users will see a 25% load on top of the non-tobacco user rate.
- CSR plan induced utilization – individuals who qualify for CSR variations of silver plans may have different utilization patterns than individuals on standard silver plans because a higher consumption rate of services is anticipated when benefits have lower member cost-share. The impact of this occurrence, although minimal, has been included in the morbidity load and is expected to increase average utilization for the individual market in 2014.

- Demographic Adjustment – The experience underlying the Manual Rate development does not conform to the 3:1 age slope as prescribed by the ACA. Hence, a minimal adjustment was made to reflect the impact of compression of age slopes as well as to account for the different distribution by age in the 2014 individual market as opposed to the distribution by age reflected in the data underlying the Manual Rate.
- Impact of EHB – Most EHBs are already represented in the base experience underlying the derivation of the Manual Rate. However, certain EHBs are not represented in the base experience and the impact of covering these benefits is subsequently added to the Manual Rate, resulting in a 0.2% load.
- Network Savings – CHLIC's underlying network for its proposed plans in this filing is different from the network underlying the experience used in deriving the Manual Rate. The estimated savings of the new provider network vary by geographic region, but are incorporated into the Manual Rate based on assumed enrollment by region as an average 4.4% decrement.

c. Inclusion of Capitation Payments

There are no services provided under a capitation arrangement for plans included in this filing.

7. CREDIBILITY OF EXPERIENCE

Since there is no experience data in Worksheet 1 of the Part 1 URR Template, 100% credibility is assigned to the Manual Rate. We believe that the Manual Rate is appropriate for developing rates for the plans in this filing, as explained in sections 6(a) and 6(b).

8. PAID TO ALLOWED RATIO

The expected cost-sharing ratio for each benefit plan is calculated by using group experience over the experience period (trended to the proposed filing period) to develop a claims probability distribution (CPD). This CPD is then utilized to estimate member cost-share vs. issuer cost-share for each benefit category and benefit plan. The Paid-to-Allowed Ratio is derived by applying expected distribution of business by benefit plan to the cost-share estimates. The expected distribution of business by benefit plan originates from CHLIC's internal estimates.

The paid-to-allowed ratio for each plan in this filing is consistent with the Actuarial Value of the plans. However, fluctuations do exist as a result of differences in the experience underlying CHLIC's manual rate and the experience underlying the continuance tables in the AV calculator. These dissimilarities result from the following differences:

- The CPD used to calculate member vs. insurer cost-share is different from the underlying claims distribution in the continuance tables of the AV Calculator. The continuance tables are based on the default standard population developed by HHS using 2010 claims and enrollment from a national commercial database. The CPD, on the other hand, is based on claims and enrollment data from Cigna's national group book of business. This experience based CPD has a larger volume of its distribution at the tail, which represents higher average costs.
- The underlying cost assumptions for copays in the AV Calculator are different than the cost assumptions determined by Cigna's experience. Since most of the proposed plans represented in this filing have copay based cost-sharing for Primary Care Physician and Specialist office visits, this causes a difference between the Paid-to-Allowed ratio and the Metal AV for most plans.

- The AV Tool only accounts for in-network benefits, whereas the paid-to-allowed ratio incorporates the impact of out-of-network benefits as well.
- Cost-sharing for certain benefits, such as separate copays for urgent care, is not captured in the AV Tool, whereas CHLIC takes these benefits into account when deriving the paid-to-allowed ratio.

9. RISK ADJUSTMENT & REINSURANCE

a. Projected Risk Adjustments (PMPM)

CHLIC is not expecting Risk Adjustment to have an impact on its index rate. While it is likely to see risk transfer payments across plans due to differences in enrolled distributions by metal level and age, CHLIC anticipates the net impact of these transfers to be negligible across the entire portfolio. The index rate has been developed to represent our expectation of the industry average medical costs as well as distribution of enrollment by age & metal tier for the Individual Market for 2014. Since we expect that CHLIC will get the same proportion by age and plan of the market as all other companies and we have factored this into the development of the index rate, there is no expected transfer payment.

b. Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

To estimate reinsurance contributions, an annual contribution of $63 per covered life is assumed. Reinsurance payments have been estimated using a representative sample of nationwide group claims data. This data consisted of member-level claims data from October 2011 through November 2012 trended to a 2014 basis. In our analysis, it is not anticipated that the increased morbidity risk will cause a higher distribution of claims to fall within or outside the parameters set for the reinsurance program. We believe that this claims data is representative of the annual distribution of claims per member we expect in 2014. Based on our claims data and the federal reinsurance parameters, we estimate that reinsurance will cover 12.5% of paid claims. This 12.5% decrement to medical costs is applied evenly across all plans as a constant multiplicative factor.

The net effect on plan costs (contributions minus payments) is expected to be $28.81 PMPM. Since reinsurance payments are calculated as a percentage of medical costs, but the contribution is a fixed PMPY, the expected impact PMPM is based on CHLIC's assumed distribution of membership across plans and ages.

10. NON-BENEFIT EXPENSES, PROFIT, & RISK

The following table illustrates anticipated breakdown of the retention components. It should be noted that the administrative expenses below reflect that CHLIC is pricing to scalable membership. Hence, these expenses reflect the PMPM amount that will be incurred if CHLIC attains scale, which is not anticipated for the rating period. Actual expenses on both a PMPM and percentage of premium basis will vary based on the actual size and distribution of membership by age and plan.

Retention Component	% of Premium
Administrative Expense	8.9%
Profit Margin	2.5%
Taxes & Fees (including ACA expenses)	6.7%
Total Retention	**18.1%**

a. Administrative Expense Load

CHLIC's non-medical expenses are split out as follows:

- Acquisition admin expense – this includes, but is not limited to, incentive compensation & salaries for brokers and agents, commissions†, marketing costs (working media & non-working media), and vendor fees.
- Recurring admin expense – this includes, but is not limited to, costs relating to customer analytics, service operations, account management, and corporate overhead.

The administrative expense load is based on internal estimates from CHLIC's Financial Analysis team and is deemed appropriate for the plans proposed in this filing. To determine this load, membership for CHLIC's benefit plans is projected as outlined in Section 15.

This membership is then applied to known budgeted amounts for administrative expenses to determine a PMPM amount across all plans. The percentage load for administrative expenses varies by plan as the PMPM value represents a higher proportion in plans with lower premiums. Based on the projected enrollment, this load is expected to be 8.9% as shown above. In the event that actual membership size and distribution differs from expectations, this figure may vary.

† Commissions vary based on distribution channel. Since premium rates for plans must be the same across all channels, CHLIC has socialized its commissions based on expected membership distribution by acquisition type. CHLIC expects its exchange customers to be referred through a blend of all distribution channels (i.e. broker, direct to consumer, etc.) and purely via the Exchange without any external referral. Hence, the commissions for the Exchange channel are calculated as a weighted average of these acquisition types.

b. Profit & Risk Margin

CHLIC has targeted a 2.5% profit margin that is built into its premium rates. This target is based on CHLIC attaining scalable membership, which is not expected for the rating period. In the event that actual membership size and distribution differs from expectations, the actual profit margin may vary. There is no additional risk margin load.

c. Taxes & Fees

Please note that the TRP fee has been included in Section 9b with the projected reinsurance recoveries and has not been included in the taxes & fees shown in this section.

- Premium Tax for the State of Tennessee is applied as 1.75% of premium
- Exchange User Fee is applied as 2.80% of premium‡ PCORI Fee is applied as $2.00 PMPY
- Health Insurer's Fee is applied as 2.20% of premium
- Risk Adjustment User Fee is applied as $1.00 PMPY

‡ Exchange User Fees are applied as an adjustment to the index rate at the market level. Hence, the 3.50% Exchange User Fee is blended based on expected member distribution on and off exchange, resulting in the 2.80% expected fee.

11. PROJECTED LOSS RATIO

The projected 2014 PPACA MLR, without adjustment for credibility, for CHLIC individual products is 83.10%.
A demonstration of projected MLR is illustrated below:

PPACA 2014 MLR			
1	Member Months	$	30,951
2	Incurred Claims	$	8,278,410
3	Claims Adjustment*	$	(962,365)
4	**Numerator (2 + 3)**	**$**	**7,316,045**
5	Earned Premium	$	9,054,511
6	Premium Adjustment**	$	(250,481)
7	**Denominator (5 + 6)**	**$**	**8,804,031**
8	Credibility Factor		5.15%
9	Avg Deductible Factor		131.90%
10	Credibility Adjustment (8 x 9)		6.80%
11	**PPACA MLR w/o Credibility (4 ÷ 7)**		**83.10%**
12	PPACA MLR w/ Credibility (10 + 11)		89.89%

* Quality Improvement Activities, Traditional Reinsurance Receipts, Net Risk Adjustment & Risk Corridor Receipts
** Premium/Payroll/Federal Income Tax and ACA Fee Adjustments

Figures in the PPACA MLR exhibit have been calculated as follows:

- Member Months – projections for member months are developed internally as best estimates generated by applying current market share percentages and additional adjustments to take into account the addressable market opportunity. This figure ties to Cell X47 in Worksheet 1 of the Part 1 URR Template.
- Incurred Claims – projections for incurred claims are developed by applying the anticipated loss ratio before reinsurance recoveries to the projected earned premium.
- Claims Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2014 (Final Rule)
- Earned Premium – projections for earned premium are developed by applying the projected average rate PMPM from Cell F80 in Worksheet 2 of the Part 1 URR Template to the expected member months projections specified earlier.
- Premium Adjustment – defined as specified by HHS Notice of Benefit & Payment Parameters for 2014 (Final Rule)
- Credibility Adjustment – The credibility adjustment is calculated using the methodology specified in 45 CFR 158.232. This adjustment incorporates the impact of the base credibility factor and the average deductible factor.

12. INDEX RATE

The Index Rate for the Projection Period identified in Worksheet 1, Section 3, of the Part 1 URR Template was generated using the same methodology as used in determining the Single Risk Pool Gross Premium Average Rate (PMPM) in Cell V43 of Worksheet 1 in the Part 1 URR Template. Hence, the Projected Index Rate is a representation of the expected Allowable Claims PMPM for 2014 and it incorporates the impact of trend, benefit, and demographic differences. Furthermore, there are no benefits in excess of EHBs that are being covered under the proposed plans in 2014. No consideration is granted to the expected impact of specific eligibility categories for catastrophic plans because these plans are not being proposed in this filing and we do not plan to offer them in 2014.

As mentioned earlier, CHLIC is not expecting risk adjustment to have an impact on its index rate as we anticipate the net impact of transfer payments across plans to be negligible across the entire portfolio. The index rate has also been adjusted for net recoveries resulting from the reinsurance program. This equates to an impact of $28.81 PMPM on the index rate.

It should be noted that only the following allowable modifiers (as specified in 45 CFR 156.80(d)) have been used to adjust the projected index rate to arrive at each plan-level rate:

- The AV of the plan
- The cost-sharing design of the plan
- The plan's provider network, delivery system characteristics, and utilization management practices
- Administrative costs, excluding Exchange user fees

The derivation of the plan level rate from the index rate is illustrated in Section 14 below.

13. AV METAL VALUES

The AV Metal Values shown in Worksheet 2 of the Part 1 URR Template were based entirely on the AV Calculator, with the exception of the following benefits:

- Cost Sharing for Pharmacy Generic Drugs
- Cost-Sharing for Pharmacy Retail vs. Home-Delivery Service
- Limited Specialist Copays (for benefit plans with limited specialist office visits)

These benefits were outside the scope of the AV Calculator and hence an alternate methodology was deemed necessary as per 45 CFR 156.135(b). This alternate methodology and the reason for its use is explained in the accompanying actuarial certification titled "Unique Plan Design Supporting Documentation & Justification".

14. AV PRICING VALUES

Pricing AV represents the cost to CHLIC of providing coverage under each plan (incurred claims & administrative costs) as a percentage of the cost of providing coverage for a fixed reference plan. The fixed reference plan, in this case, is selected as Plan 99248TN0020007.

A demonstration of how the Pricing AV's are derived from the Metal AV's is shown below:

Derivation of Pricing AV from Metal AV							
	Plan ID						
	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Metal AV	58.2%	60.3%	68.4%	69.1%	69.4%	78.6%	80.6%
Benefits Additional to EHBs	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Impact of Provider Network	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Admin Costs (excluding Exchange User Fee)	1.01	1.01	1.00	1.00	1.00	0.99	0.98
Impact of Cost-Sharing Design	0.98	0.98	1.00	0.98	1.01	1.01	1.05
Adjusted AV	57.6%	59.4%	68.2%	67.5%	69.9%	78.2%	82.8%
Pricing AV	69.6%	71.8%	82.4%	81.6%	84.4%	94.4%	100.0%

- It should be noted that although "Impact of Provider Network" is shown as having no impact in the calculation above, the preceding table illustrates an average across the entire state. Hence, premium rates may vary between rating areas within the state as a result of differences in medical costs and provider contracts, which is not reflected above. Nevertheless, there is no impact due to provider network by benefit plan as there is no variation in provider network or delivery systems across plans, only by area.
- "Admin costs" are calculated on a PMPM and percentage of premium basis and, thus, may vary as a percentage of premiums across plans. Consequently, that impact is captured in the table above.
- The "Impact of Cost Sharing Design" corresponds to differences in utilization patterns for service categories between the AV Calculator and the data underlying the derivation of the Manual Rate. This difference was estimated by running the proposed plan designs through the AV Calculator (using its standard continuance tables) and then through CHLIC's pricing model with the CPD that serves as the underlying dataset for derivation of the Manual Rate. The difference between the two approaches was then subsequently quantified.

CHLIC is not incorporating any impact of different morbidity or health status of individuals who select certain plans in the derivation of the Pricing AV from the Metal AV.

The Adjusted AV represents the impact of applying the allowable modifiers to the Metal AV, which is shown in the table above. The Pricing AV demonstrates the relationship of the Adjusted AV between each respective plan and the reference plan, Plan 99248TN0020007.

15. MEMBERSHIP PROJECTIONS

The membership projections for CHLIC's benefit plans are developed internally as best estimates generated by applying CGLIC's current market share percentages to the addressable market opportunity developed by an SOA sponsored study, "Cost of the Future Newly Uninsured under the Affordable Care Act (ACA)". There have been additional adjustments made to take into account specific market strategies including the anticipated impacts of the new networks developed by CHLIC.

For Silver metal plans, the projected enrollment subject to cost-sharing reduction subsidies at each level is developed based on the Distribution of Population by FPL as outlined in the SOA sponsored study, "Design & Implementation Considerations of ACA Risk Mitigation Programs". CHLIC applied adjustments to the results of the study to account for expected differences in the general population and anticipated covered population that are outlined below:

- It is assumed that not all individuals above the 250% FPL level will buy silver plans, as some of them may opt for benefit plans on a different metal tier.
- Since Tennessee has opted for expansion of its Medicaid program, only the 139%-150% FPL bracket was considered when developing an estimate for the population that will enroll in the 94% Silver CSR plan.
- The study mentioned above did not split out the 200%-299% FPL bracket. For purposes of this calculation, it was assumed that the population is uniformly distributed within that bracket. Hence, 50% of the 200%-299% FPL bracket was assumed to fall in the 200%-250% FPL bracket and, thus, be eligible for the 73% Silver CSR plan.

The resulting projected enrollment by plan and subsidy level is outlined below:

Distribution by Plan by CSR-Level				
Plan ID	**139%-150% FPL**	**150%-200% FPL**	**200%-250% FPL**	**>250% FPL**
99248TN0020003	6%	25%	20%	49%
99248TN0020004	6%	25%	20%	49%
99248TN0020005	6%	25%	20%	49%

16. TERMINATED PRODUCTS

The following benefit plans will be terminated as of 1/1/2014 and will no longer be available for new sales. It should be noted that there is no membership on any of these plans as of today. As these plans do not have Component Plan IDs, we have shown "0000" for this field in the URR Template Worksheet 2.

- Open Access 2000
- Open Access 3000
- HIPAA 2000
- HIPAA 3000

17. PLAN TYPE

All plans in this filing are categorized as PPO plans.

18. WARNING ALERTS

Cell A82 – This cell shows a "Warning", indicating that the Total Premium built up on Wksh 1 – Market Experience does not equal the Total Premium on Wksh 2 – Plan Product Info. Internally, we do not build up our rates in the exact same manner as in Wksh 1, so while the premiums are similar, they will not be exactly equal. However, as can be seen in cells B80 and F80 the premiums PMPM are within 2% of each other. Wksh 2 forces the projected member months (row 47) to be rounded, so even if the premiums were identical, instead of within 2% of each other, there would still be a "Warning" displayed in cell A82.
Cell A86 – We believe the formula in cell B86 is incorrect, as B86 calculates allowed premiums net of reinsurance and risk adjustment, whereas the instructions indicate this number should be gross of reinsurance and risk adjustment. If we change the calculations in row 86 to be net of reinsurance and risk adjustment, cell A86 will display "Ok"; however, doing so will cause an error in cell A99, which looks at the Allowed Claims PMPM gross of reinsurance and risk adjustment.

19. EFFECTIVE RATE REVIEW INFORMATION

a. Financial Information

Cigna Health & Life Insurance Company (CHLIC)				
($ Millions)	**2010**	**2011**	**2012**	**2013 (Proj)**
Stat Capital & Surplus *[Pg 3, Line 38]*	**51**	**543**	**1,018**	**1,933**
Authorized Control Level RBC	**3**	**44**	**172**	**366**

CHLIC is in strong financial condition. The YE 2012 ACL RBC ratio was 605%. In prior years when the Company was significantly smaller, the RBC ratio was much higher. For the next few years, we expect to maintain an ACL RBC ratio in the 500% to 600% range. The proposed plans and rates will have an immaterial impact on the company's financial condition, even with significant membership growth.

b. Rating Information

Premium rating rules as per PPACA have been adhered to. CHLIC is only adjusting premium rates for the following factors:

- Age – the Federal Age Slope as prescribed by HHS is used to determine rates by age.
- Area – rates vary by prescribed rating areas as shown in the rates template.
- Tobacco – rates vary by tobacco usage, but not by more than a 1.5:1 ratio as shown in the rates template.
- Family size – A maximum of 3 dependents under the age of 21 will be used to determine a rate for a family policy as shown in the business rules template.

To see the proposed rate manual by age, area and tobacco user status please reference the accompanying Rate Template. For other rating rules used in deriving the premium please refer to the accompanying Business Rules Template.

A description of the benefits for all plans proposed in this filing is shown in the accompanying PlansBenefits Template.

Please note that CHLIC shall satisfy the requirement to offer coverage for all essential health benefits off-exchange by providing all applicants both a medical policy that does not include a pediatric dental benefit and a standalone exchange-certified pediatric dental policy.

c. Other

CHLIC's anticipated loss ratio (without ACA adjustments) for the proposed plans in this filing is 80%.

20. RELIANCE

In preparing the Part 1 Unified Rate Review Template submission, I have relied on data and analysis provided by Mitchell Pawlowski. In addition, I have relied on external sources in order to develop the underlying assumptions for the development of the proposed premium rate. These sources are outlined below:

- Clark, A. (FSA, MAAA), & O'Connor, J. T. (FSA, MAAA).
  Design and Implementation Considerations of ACA Risk Management Programs.
  Society of Actuaries (2012)
- Haught, R., & Ahrens, J.
  Cost of the Future Newly Insured under the Affordable Care Act (ACA).
  Society of Actuaries (2012)

21. ACTUARIAL CERTIFICATION

I, Lauren Danziger, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I certify, to the best of my knowledge and judgment, that:

a) The rates proposed in the above noted rate filing are
   - In compliance with all applicable State & Federal Statutes & Regulations (45 CFR 156.80(d)(1))
   - Developed in compliance with applicable Actuarial Standards of Practice, including but not limited to the following:
     - ASOP #5, Incurred Health & Disability Claims
     - ASOP #8, Regulatory Filings for Health Plan Entities
     - ASOP #12, Risk Classification
     - ASOP #23, Data Quality
     - ASOP #25, Credibility Procedures Applicable to Accident & Health, Group Term Life, and Property & Casualty Coverages
     - ASOP #26, Compliance with Statutory & Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
     - ASOP #41, Actuarial Communications
   - Reasonable in relation to the benefits provided and the population anticipated to be covered and that the rates are not excessive, inadequate or unfairly discriminatory

b) Plan level rates were generated using only the index rate and allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2)

c) The percent of total premium that represents essential health benefits included in Worksheet 2, Section IV, of the Part 1 URR Template was calculated in accordance with applicable Actuarial Standards of Practice

d) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans, save the exceptions shown in Section 13 and which are further explained in the accompanying actuarial certification "Unique Plan Design Supporting Documentation & Justification".

Lauren Danziger

Lauren Danziger, FSA, MAAA
Actuarial Manager
Cigna Health & Life Insurance Company
Lauren.Danziger@Cigna.com

April 22, 2013
Date

Data Collection Template

Company Legal Name:	**Cigna Health and Life Insuranc**	State:	**TN**
HIOS Issuer ID:	**99248**	Market:	**Individual**
Effective Date of Rate Change(s):	**01/01/2014**		

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 01/01/2012 to 12/31/2012

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$6	$0.89	100.00%
Incurred Claims in Experience Period	$5	0.67	75.00%
Allowed Claims:	$7	1.00	112.50%
Index Rate of Experience Period		$1.00	
Experience Period Member Months	7		

Section II: Allowed Claims, PMPM basis

Projection Period: 01/01/2014 to 12/31/2014 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual		
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**
Inpatient Hospital	Admits	2,000.00	$1.00	$0.17	1.000	1.000	1.000	1.000	2,000.00	$1.00	$0.17	92.28	$13,000.55	$99.98
Outpatient Hospital	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	394.74	1,986.66	65.35
Professional	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	6677.06	150.66	83.83
Other Medical	Visits	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	2095.42	406.03	70.90
Capitation	Services	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	1.00	1.00	0.00
Prescription Drug	Prescriptions	2,000.00	1.00	0.17	1.000	1.000	1.000	1.000	2,000.00	1.00	0.17	8219.83	88.22	60.43
Total				$1.00							$1.00			$380.48

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$380.48	$11,776,386
Paid to Allowed Average Factor in Projection Period			0.716	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$272.47	$8,433,205
Projected Risk Adjustments PMPM			0.00	0
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$272.47	$8,433,205
Projected ACA reinsurance recoveries, net of rein prem, PMPM			28.81	891,658
Projected Incurred Claims			$243.66	$7,541,547
Administrative Expense Load		8.88%	26.44	818,234
Profit & Risk Load		2.50%	7.44	230,276
Taxes & Fees		6.74%	20.06	620,988
Single Risk Pool Gross Premium Avg. Rate, PMPM			$297.60	$9,211,045
Index Rate for Projection Period			$380.48	
% increase over Experience Period			33380.10%	
% Increase, annualized:			1729.76%	
Projected Member Months				30,951

Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Product-Plan Data Collection

Company Legal Name:	**Cigna Health and Life Insurance Company**	State:	**TN**
HIOS Issuer ID:	**99248**	Market:	**Individual**
Effective Date of Rate Change(s):	**01/01/2014**		

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		OAP	LocalPlus						
Product ID:		99248TN001	99248TN002						
Metal:		Catastrophic	Bronze	Bronze	Silver	Silver	Silver	Gold	Gold
AV Metal Value		0.000	0.582	0.603	0.684	0.691	0.694	0.786	0.806
AV Pricing Value		0.001	0.696	0.718	0.824	0.816	0.844	0.944	1.000
Plan Type:		PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan Name		Terminated Products	myCigna Health Savings 6100	myCigna Health Flex 5500	myCigna Health Savings 3400	myCigna Health Flex 1500	myCigna Health Flex 5000	myCigna Health Savings 1900	myCigna Health Flex 1250
Plan ID (Standard Component ID):		99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Exchange Plan?		No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Historical Rate Increase - Calendar Year - 2		0.00%	0.00%						
Historical Rate Increase - Calendar Year - 1		0.00%	0.00%						
Historical Rate Increase - Calendar Year 0		0.00%	0.00%						
Effective Date of Proposed Rates		01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014	01/01/2014
Rate Change % (over prior filing)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%	-999.00%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	32811.13%	32811.13%	32811.13%	32811.13%	32811.13%	32811.13%	32811.13%
Product Threshold Rate Increase %		#DIV/0!	0.00%						

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Inpatient	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Outpatient	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Professional	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Prescription Drug	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Other	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Capitation	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Administration	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Taxes & Fees	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Risk & Profit Charge	$1.00	$0.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
Total Rate Increase	$9.00	$0.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00	$9.00
Member Cost Share Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Average Current Rate PMPM	$292.54	$0.00	$292.54	$292.54	$292.54	$292.54	$292.54	$292.54	$292.54
Projected Member Months	30,954	0	4,422	4,422	4,422	4,422	4,422	4,422	4,422

:tion III: Experience Period Information

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Average Rate PMPM	$0.89		$0.89	$0.89	$0.89	$0.89	$0.89	$0.89	$0.89
Member Months	7		1	1	1	1	1	1	1
Total Premium (TP)	$6	$0	$1	$1	$1	$1	$1	$1	$1
EHB basis or full portion of TP, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$7		$1	$1	$1	$1	$1	$1	$1
EHB basis or full portion of TAC, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	$2		$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0		$0	$0	$0	$0	$0	$0	$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Incurred claims, payable with issuer funds	$5	$0	$1	$1	$1	$1	$1	$1	$1
Net Amt of Rein	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Net Amt of Risk Adj	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Incurred Claims PMPM	$0.67	#DIV/0!	$0.67	$0.67	$0.67	$0.67	$0.67	$0.67	$0.67
Allowed Claims PMPM	$1.00	#DIV/0!	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
EHB portion of Allowed Claims, PMPM	$1.00	#DIV/0!	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00

:tion IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	99248TN0010000	99248TN0020001	99248TN0020002	99248TN0020003	99248TN0020004	99248TN0020005	99248TN0020006	99248TN0020007
Average Rate PMPM	$292.54	$0.00	$292.54	$292.54	$292.54	$292.54	$292.54	$292.54	$292.54
Member Months	30,954	-	4,422	4,422	4,422	4,422	4,422	4,422	4,422
Total Premium (TP)	$9,055,389	$0	$1,293,627	$1,293,627	$1,293,627	$1,293,627	$1,293,627	$1,293,627	$1,293,627
EHB basis or full portion of TP, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	$11,777,527		$1,682,504	$1,682,504	$1,682,504	$1,682,504	$1,682,504	$1,682,504	$1,682,504
EHB basis or full portion of TAC, [see instructions]	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	$4,235,249		$605,036	$605,036	$605,036	$605,036	$605,036	$605,036	$605,036
Portion of above payable by HHS's funds on behalf of insured person, in dollars	$415,449		$59,350	$59,350	$59,350	$59,350	$59,350	$59,350	$59,350
insured person, as %	9.81%	#DIV/0!	9.81%	9.81%	9.81%	9.81%	9.81%	9.81%	9.81%
Total Incurred claims, payable with issuer funds	$7,542,278	$0	$1,077,468	$1,077,468	$1,077,468	$1,077,468	$1,077,468	$1,077,468	$1,077,468
Net Amt of Rein	$891,744		$127,392	$127,392	$127,392	$127,392	$127,392	$127,392	$127,392
Net Amt of Risk Adj	$0		$0	$0	$0	$0	$0	$0	$0