Connecticut General Life Insurance Company may change the premiums of this Policy after 30 day's 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 Policy as You.

Connecticut General Life Insurance Company ("CIGNA")
Individual Plan
California Open Access 5000

Pre-existing Condition Limitations

Any services received on or within 6 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.

This is a High-Deductible Policy. This policy will not begin to pay for your health care expenses until after your health care bills exceed the deductible amount. You will have to pay for all of your health care bills until these bills exceed your deductible amount.

Notice of Ten-Day Right to Examine Policy

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 except for Federally Eligible Defined Individuals 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
1-877-484-5967

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

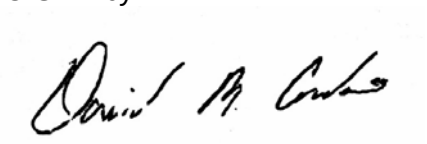
THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by CONNECTICUT GENERAL LIFE INSURANCE COMPANY (referred to herein as CIGNA) based on the information You provided in Your application, a copy of which is attached to the Policy. If You know of any misstatement in Your application, 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.

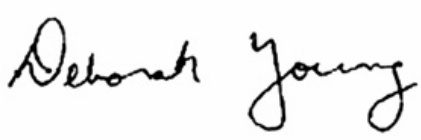
Guaranteed Renewable

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.**

Signed for CIGNA by:



David M. Cordani, President



Deborah Young, Corporate Secretary

COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE. This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-house medical services, out of hospital care, and prosthetic devices, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the Policy.

Independent Medical Review

You have the right to request an Independent Medical Review when you believe health care services have been improperly denied, modified or delayed by CIGNA or a Participating Provider. Refer to the section of this Policy entitled "When you have a Complaint or Adverse Determination Appeal" for more information.

Accessing Health Care

To contact the Department of Insurance, for complaints regarding Your ability to access health care in a timely manner, write or call:
Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013
Calling within California: 1-800-927-4357
Los Angeles Area and Outside California: 1-213-897-8921
The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

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!** Terminology such as **Deductible, Covered Expense,** and **Out-of-Pocket Maximum** are listed alphabetically in the "Definitions" section of the Policy.

The benefits outlined in the table below show the payment percentages and copays for Covered Expenses **AFTER** any applicable Deductibles have been satisfied and prior to meeting any Out of Pocket Maximum unless otherwise stated.

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Medical Benefits		
Annual Deductible Individual Family ***Note:*** *Additional Deductibles may apply to specific benefits.*	**In-Network Deductible** $5,000 $10,000	**Out-of-Network Deductible** $10,000 $20,000
Out-of-Pocket Maximum Individual Family	Excluding Penalties and Policy Maximums, Deductibles, Copayments, RX charges. **In-Network Out-of-Pocket Maximum** $5,000 $10,000	Excluding Penalties and Policy Maximums, Deductibles, Copayments, RX charges. **Out-of-Network Out-of-Pocket Maximum** $10,000 $20,000
Coinsurance	CIGNA pays 70% of eligible charges. You and Your Family Members pay 30% of Charges after the Policy Deductible.	CIGNA pays 50% of eligible charges. You and Your Family Members pay 50% of Charges after the Policy Deductible.
Prior Authorization Program **Prior Authorization – Inpatient** **Please refer to the section on Prior Authorization of inpatient services for more information.**	You, Your Family Member(s), or your Provider must obtain approval for inpatient admissions; or You may be subject to a $500, penalty for non-compliance.	You and Your Family Member(s) must obtain approval for inpatient admission; or You may be subject to $500, penalty for non-compliance.
Prior Authorization – Outpatient Please refer to the section on Prior Authorization of outpatient services for more information.	You, Your Family Member(s), or your Provider must obtain approval for selected outpatient procedures and diagnostic testing; or You may be subject to a $60, penalty for non-compliance.	You and Your Family Member(s) must obtain approval for selected outpatient procedures and diagnostic testing; or You may be subject to $60, penalty for non-compliance.
Lifetime Maximum	$6,000,000 per Insured Person	

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Pre-existing Condition Limitation applies **(***but may be reduced by Insured Person's prior eligible Creditable Coverage. See the definition of Pre-existing Condition.)*	Yes	Yes
Preventive Care **<u>Babies/Children through age 6</u>** Office Visit	$30/$40 copayment	50%
Lab work	70% with Deductible waived	50% with Deductible waived
Immunizations	70% with Deductible waived	50% with Deductible waived
<u>Adults and Children (age 7 and up)</u> Office Visits/examination related to mammograms, PSA, Pap test, HPV screening, breast cancer test based on generally accepted medical guidelines or scientific evidence.	$30/$40 copayment	50%
Routine Preventive Care (including mammograms, PSA, Pap Test, HPV screening, breast cancer test based on generally accepted medical guidelines or scientific evidence.) (Mammogram charges do NOT apply to preventive care dollar maximum if performed in physician's office. PSA Pap Test, HPV screening and breast cancer test based on generally accepted medical guidelines or scientific evidence charges if billed by physician's office do NOT apply to the preventive care dollar maximum.)	$30/$40 copayment	50%
All Other Routine Services Routine Physicals to include Immunizations, flu shots, and lab work *$250 maximum payment per Insured Person, per Calendar Year age 7 and up, combined in or out of network*	$30/$40 copayment then Plan pays 100%, Deductible waived	50%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Physician Services		
Primary Care Physician (PCP) Office Visit	$30 Copayment	50%
Specialty Physician Office Visit Consultant and Referral Physician Services ***Note:*** *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.*	$40 Copayment	50%
Allergy Treatment/Injections (PCP or Specialist)	70%	50%
Second Opinion Consultations	$30/$40 copayment	50%
Surgery Performed in the Physician's Office (PCP or Specialist)	70%	50%
Surgeon, Anesthesia, Radiation Therapy, In-hospital visits, diagnostic x-ray and lab	70%	50%
Hospital Services		
Inpatient Hospital Services	70%	50%
Emergency Admissions ***Note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	70%	50%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Outpatient Diagnostic and Free-Standing Outpatient Surgical Facility Services ***Note:*** *Prior Authorization from CIGNA is required for specified outpatient surgeries and diagnostic procedures*	70%	50%
Emergency Services Emergency Room (additional deductible waived if admitted) Ambulance includes emergency transportation to the nearest facility only.	70% $100 Additional Deductible 70%	50% $100 Additional Deductible 50%
Urgent Care	70%	50%
Advanced Radiological Imaging (including MRI, MRA, CAT Scan, PET Scan) ***Note:*** *Prior Authorization from CIGNA is required for specified diagnostic procedures*	70%	50%
All Other Laboratory and Radiology Services Physician's Office Any other x-ray lab facility including outpatient facility	70% 70%	50% 50%
Physical, Occupational, Speech Therapy and Spinal Manipulation *24 visit maximum per Insured Person, per Calendar Year for all therapies combined In and Out of Network*	70%	50%
Cardiac & Pulmonary Rehabilitation	70%	50%
Complications of Pregnancy	70%	50%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Dental Care For accidental injury to natural teeth, within 6 months of the date of injury Anesthesia for dental procedures for a dependent child under age 7	70% 70%	50% 50%
Phenylketonuria (PKU) Testing and Treatment **Medical Foods** *to treat PKU*	70% 70%	50% 50%
Inpatient Services at Other Health Care Facilities, Skilled Nursing, Rehabilitation Hospital and Subacute Facilities ***Note:*** *Prior Authorization from CIGNA is required for all Inpatient Services* *30 day maximum per Insured Person, per Calendar Year combined for all facilities, In and Out of Network combined.*	70%	50%
Home Health Services ***Note:*** *Prior Authorization from CIGNA is required for all Home Health Services* *30 visit maximum per Insured Person, per Calendar Year, In and Out of Network combined*	70%	50%
Temporomandibular Joint Dysfunction	70%	50%
Durable Medical Equipment ***Note:*** *Prior Authorization from CIGNA is required for all Durable Medical Equipment* *Annual maximum $2,000*	70%	50%
Hospice ***Note:*** *Prior Authorization from CIGNA is required for all Hospice Services*	70%	50%
Severe Mental Illness at any age and Serious Emotional Disturbances of a Dependent child under age 18 Inpatient Outpatient	70% 70%	50% 50%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Mental, Emotional or Functional Nervous Disorders and Substance Abuse		
Inpatient *30 day maximum combined in and out of network per Insured Person, per Calendar Year* ***Note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	70%	50%
Outpatient *20 day maximum combined in and out of network per Insured Person, per Calendar Year*	70%	50%
Organ and Tissue Transplants *(See benefit detail for covered procedures and other benefit limits which may apply.)*		
CIGNA Lifesouce Transplant Network® Facility	100%	*NOT APPLICABLE*
Other CIGNA Network Facility Contracted to Provide Transplant Benefits ***Note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	70%	50%
Travel Benefit (Only available through CIGNA Lifesource Transplant Network® Facility)	$10,000	*NOT APPLICABLE*
Travel Maximum per person per lifetime	$10,000	*NOT APPLICABLE*

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge)
Prescription Drugs Benefits		
CIGNA Pharmacy Retail Drug Program		
Brand Name Prescription Drug Deductible	$500 per Insured Person, per Calendar Year	$500 per Insured Person, per Calendar Year
Generic drugs- *on the Prescription Drug List for a 30-day supply*	$10 Copayment per prescription/refill	50% per prescription/refill
Brand Name drugs designated as preferred- *on the Prescription Drug List with no Generic equivalent for a 30- day supply*	$35 Copayment per prescription/refill	50% per prescription/refill
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred- *on the Prescription Drug List for a 30-day supply*	$60 Copayment per prescription/refill	50% per prescription/refill
Self-administered injectables- *(e.g., drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma)*	CIGNA Pays 70%	50% per prescription/refill
CIGNA Tel-Drug Mail Order Drug Program		
Generic drugs- *on the Prescription Drug List for a 90-day supply*	$25 Copayment per prescription/refill	N/A
Brand Name drugs designated as preferred- *on the Prescription Drug List with no Generic equivalent for a 90-day supply*	$85 Copayment per prescription/refill	N/A
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred- *on the Prescription Drug List for a 90-day supply*	$150 Copayment per prescription/refill	N/A
Self-administered injectables- *(e.g., drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma)*	CIGNA Pays 70%	N/A

Cancer Screening Tests

Benefits are payable for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence.

Treatment of Diabetes

Medical services for Diabetes are paid on the same basis as any other medical condition. Benefits provided for Covered Expenses include outpatient Diabetes Self-Management Training, education and medical nutrition therapy, Diabetes Equipment and Diabetes Pharmaceuticals & Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

Treatment Received from Foreign Country Providers

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

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

Mastectomy and Related Procedures

Benefits are payable for hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer or for a period of time determined by a Physician in consultation with the patient. 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.

Conditions Attributable to Diethylstilbestrol

Medical services for conditions attributable to diethylstilbestrol are paid on the same basis as any other medical condition.

Prosthetic Appliances following Laryngectomy

Benefits are payable for prosthetic appliances, including devices to restore a method of speaking following a laryngectomy, other than electronic voice-producing machines.

Off Label Drugs

A drug that has been prescribed for purposes other than those approved by the FDA will be covered if:

a) the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition; (b) the drug has been recognized for the treatment prescribed by either the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, the U.S. Pharmacopeia Dispensing Information, or two articles from major peer reviewed medical journals that are not contradicted by another such article; and (c) the drug is otherwise approved by the FDA.

Cancer Clinical Trials

Benefits are payable for an Insured diagnosed with cancer and accepted into a phase I through IV clinical trial for cancer for all routine patient care costs related to the clinical trial if the Insured's treating Physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Insured.

The clinical trial must meet the following requirements:

- The trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.
- The treatment provided in a clinical trial must either be:
    1. Approved by the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans' Administration, or
    2. Involve a drug that is exempt under federal regulations from a new drug application.

Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered by the CIGNA if they were not provided in connection with a clinical trial, including the following:

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

If the clinical trial is conducted by a non-Participating Provider, the payment shall be at the negotiated rate that CIGNA would otherwise pay to a Participating Provider for the same services, less any applicable Copayments and deductibles.

CIGNA may restrict coverage for clinical trials to Participating Hospitals and Physicians in California, unless the protocol for the trial is not provided in California.

Telemedicine

Benefits for Telemedicine are payable as any other medical condition. Telemedicine include the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Interactive means an audio, video, or data communication involving a real time (synchronous) or near real time (synchronous) two-way transfer of medical data and information.

AIDS Vaccines

Benefits are payable for vaccines for AIDS that are approved for marketing by the federal FDA and that are recommended by the United States Public Health Service. Coverage will not be provided for any clinical trials relating to an AIDS vaccine or for any AIDS vaccine that has been approved by the federal Food and Drug Administration in the form of an investigational new drug application.

HIV Testing

Benefits are payable for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

Exclusions And Limitations: What The Policy Does Not Cover

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.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** in this Policy as Covered Services.
- 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 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;** (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.**
- Any services provided by a local, state or federal **government agency,** except when payment under this Policy is expressly required by federal or state law.
- If the Insured Person is eligible for **Medicare** part A or B 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.
- Any services for which payment may be obtained from any local, state or federal **government agency** (except Medicaid or Medi-Cal). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption.
- **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.
- Treatment of **Mental, Emotional or Functional Nervous Disorders** or psychological testing except as specifically provided in this Policy.
- **Smoking cessation** programs.
- 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**.
- Routine **hearing tests** except as provided under Well Baby and Well Child Care and Newborn Hearing Benefits.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy.
- 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 provided in this Policy.
- **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. This exclusion does not apply to Reconstructive Surgery services that are **not specifically listed** in this Policy as Covered Services. **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 non-medical ancillary services for learning disabilities and developmental delays.
- Services for **redundant skin surgery**, removal of skin tags, acupressure, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, pryotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This 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, except as specifically stated in this Policy.

- All **non-prescription** Drugs, devices and/or supplies that are available over the counter or without a prescription.
- **Cryopreservation** of sperm or eggs.
- **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
- 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, except as specifically stated in this Policy.
- Charges by a provider for **telephone or email consultations**.
- 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.).
- **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.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.
- **Self-administered Injectable Drugs**, except as stated 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 Benefits section of this Policy.
- **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.
- 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.
- **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 15 months from the date service was rendered, except in the event of a legal incapacity.

Pre-existing Condition Periods

Any services received by the Insured Person on or within 6 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 6 month period preceding the Effective Date of coverage.

The exclusion for Pre-existing Conditions does not apply to an Insured Person 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 before the Effective Date of the Insured Person's individual coverage, excluding any waiting period.

In determining the duration of the Pre-existing Condition exclusion, We will credit the time an Insured Person was previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding the Effective Date of the Insured Person's coverage under this Policy. Proof of coverage is required.

Pharmacy Program 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;
- 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, except that coverage for AZT will be provided;
- Off Label Drugs, except as specifically provided in this Policy;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- 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), dietary supplements, and fluoride products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as 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;
- 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;
- 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;

Pharmacy Program 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
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from CIGNA before prescribing the drugs or supplies. 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.

If the request is approved, the Physician will receive confirmation. The Prior Authorization will be processed in our claim system to allow the Insured Person 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 Physician advises the Insured Person that coverage for the Prescription Drugs or Related Supplies has been approved, the Insured Person should contact the Pharmacy to fill the prescription(s).

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

If the Insured Person disagrees with a coverage decision, they 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 questions about a specific Prior Authorization request, they should call Member Services at the toll-free number on the ID card.

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.

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 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 have 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 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.

Additional Deductibles

This benefit Policy may contain Additional Deductibles which are specific to certain benefits. Please see the Benefit Schedule for specific dollar amounts.

- Emergency room services: An **Additional Deductible** per visit will apply, unless the visit results in an inpatient admission into that Hospital immediately following the Emergency room visit.
- Pharmacy requires fulfillment of an **Additional Deductible** for Brand Name Prescription Drugs. Each Insured Person must meet the separate Deductible each Year before receiving Prescription Drug benefits for Brand Name Formulary and Non-Formulary 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

The Out of Pocket Maximums are the amount of Coinsurance 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, any Deductible amounts, any penalties, or any amounts in excess of other benefit limits of this Policy. Charges for Severe Mental Health and Serious Emotional Disturbances of a Dependent child under age 18 will apply to the Out of Pocket Maximum.

- Once an Insured Person 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), 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 or Lifetime Maximums which may apply to these specific Benefits.

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

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.

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

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:

a. Inpatient Hospital admissions without Prior Authorization may be subject to a Penalty.
b. Free Standing Outpatient Surgical Facility Services may be subject to a Penalty, per admission if You or your Provider fail to obtain Prior Authorization.
c. Specified outpatient surgeries and diagnostic procedures require Prior Authorization. You or Your Provider may be responsible for a Penalty, per admission or procedure if You or Your Provider fail to obtain Prior Authorization.
d. Authorization is required prior to receiving services from Skilled Nursing facilities, Infusion Therapy services, Extended Care Facility Services, Home Health services, Hospice services and for Organ and Tissue Transplants. Failure to obtain Authorization prior to receiving these services may result in a Penalty.

Lifetime Maximum Benefits

The combined total of all benefits paid to the Insured Person is limited to a maximum during each Insured Person's lifetime, so long as You or the Insured Person(s) remains insured under this Policy.

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 in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION MAY RESULT IN A PENALTY. REFER TO YOUR SCHEDULE OF BENEFITS FOR ADDITIONAL INFORMATION. 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. Prior Authorization requirements for inpatient services include, but may not be limited to:

- Inpatient Hospital
- Skilled Nursing Facilities
- Extended Care Facilities
- Organ and Tissue Transplants
- Hospice Care Services

Emergency Admissions
If a Physician or any emergency services provider, including a licensed ambulance service providing emergency medical transportation, initiates necessary Emergency Services treatment to stabilize the condition of a patient, the treatment will be covered without Prior Authorization.

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 select outpatient procedures in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE OUTPATIENT SERVICE MAY RESULT IN A PENALTY. REFER TO YOUR SCHEDULE OF BENEFITS FOR ADDITIONAL INFORMATION. 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.
Outpatient procedures which require Prior Authorization include, but are not limited to:

- Potential cosmetic procedures
- CT, PET scans, MRI
- Any surgeries on the above Prior Authorization list
- Speech Therapy
- Cardiac Rehabilitation
- External prosthetic devices
- Durable Medical Equipment
- Home Health Services
- Injectable drugs
- Major skin procedures
- Face/jaw surgery
- Breast reductions
- Hysterectomy
- Potential Experimental or investigational procedures
- Back/Spine Procedures

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.

WHEN YOU HAVE A COMPLAINT OR AN ADVERSE DETERMINATION APPEAL

For the purposes of this section, any reference to "You", "Your" or "Member" also refers to a representative or provider designated by You to act on Your behalf, unless otherwise noted.

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

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, You can call our toll-free number and explain Your concern to one of Our Customer Service representatives. You can also express that concern in writing. Please call or write to Us at the following:

Customer Services Toll-Free Number or address that appears on Your Benefit Identification card, explanation of benefits or claim form.

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

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

Internal Appeals Procedure

CIGNA has a one step appeals procedure for appeals decisions. To initiate an appeal, You must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why You feel your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call or write to us at the toll-free number or address on Your Benefit Identification card, explanation of benefits or claim form.

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

We will respond in writing with a decision within 30 calendar days after We receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after We receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, We will notify you in writing to request an extension of up to 30 calendar days and to specify any additional information needed to complete the review. Please note that the California Department of Insurance (CDI) does not require You to participate in CIGNA 's appeals review for more than 30 days although You may choose to do so. At the completion of this 30-day-review period, when the disputed decision is upheld or Your case remains unresolved, You may apply to the CDI for a review of Your case.

You may request that the appeal process be expedited if, Your treating Physician certifies in writing that an imminent and serious threat to Your health may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing. The Department of Insurance allows You to apply for an independent medical review after this expedited decision if you are unsatisfied with our determination.

Independent Medical Review Procedure

When the disputed decision is upheld or Your case remains unresolved after 30 days and when Your case meets the criteria outlined below, You are eligible to apply to the CDI for an Independent Medical Review(IMR). The CDI has final authority to accept or deny cases for the IMR process. If Your case is not accepted for IMR the CDI willl treat Your application as a request for the CDI itself to review Your issues and concerns. Prior to application for an IMR, You are free to seek other avenues of appeal with CIGNA. If You choose to do so, You will not forfeit Your eligibility to apply for the IMR.

The Independent Medical Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Policy.

There is no charge for You to apply for or participate in this IMR process. CIGNA will abide by the decision of the Independent Medical Review Organization.

In order to qualify for an IMR, certain conditions must be met: (1) Your Physician has recommended a health care service as Medically Necessary and CIGNA has disagreed with this determination, or (2) You have received urgent care or emergency services that a Physician has deemed Medically Necessary and CIGNA has disagreed with this determination, or (3) in the absence of (1) and (2), You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You are seeking an independent medical review and CIGNA has determined these services as not Medically Necessary or clinically appropriate. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent medical appeal under this process. You remain entitled to send such issues to the CDI for a Department review.

Independent Review Process for Experimental and Investigational Therapies

Special provisions apply to the IMR process for coverage decisions related to experimental or investigational therapies. If CIGNA denies your appeal because the requested service or treatment is experimental or investigational, CIGNA will send you a letter within 5 business days of making the denial decision. The letter will include:

- A notice explaining your right to an IMR;
- An IMR application;
- A Physician Certification Form for your physician to complete which certifies that you have a life-threatening or seriously debilitating condition; Your physician’s certification must also indicate that standard therapies have not been effective in treating your condition or the requested therapy is likely to be more beneficial than any standard therapy as documented in two separate sources of medical or scientific evidence.
- An envelope for you to return the completed forms to Us.

A “life-threatening” condition means either or both of the following:(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. A “seriously debilitating” condition means diseases or conditions that cause major irreversible morbidity.

“Medical and scientific evidence” manes any of the following:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.(4) The following standard reference compendia: The American Hospital Formulary

Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

(4) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(5) Peer-reviewed abstracts accepted for presentation at major medical association meetings.
The IMR will be conducted by an Independent Medical Review Organization which is qualified to review issues related to experimental and investigational therapies as selected by the CDI. The IMR must be completed within 30 calendar days. If Your physician determines that the proposed therapy which is the subject of the IMR would be significantly less effective if not initiated promptly, an expedited IMR is available. An expedited IMR will be completed within 7 calendar days from the date an expedited IMR was requested. This timeframe may be extended by up to 3 calendar days if there is a delay in providing any documents which the Independent Medical Review Organization requests for review. The IMR's decision must state the reason that the therapy should or should not be covered, citing your specific medical condition, the relevant documents, and the relevant medical and scientific evidence. CIGNA will cover the services subject to the terms and conditions generally applicable to other benefits under Your plan.

Appeal to the State of California

We will provide You with an application and instructions on how to apply to the CDI for an IMR. You must submit the application to the CDI within 180 days of Your receipt of our appeal review denial. In compelling circumstances, the Commissioner of Insurance may grant an extension.

The Independent Medical Review Organization will render an opinion within 30 days. If a delay would be detrimental to Your medical condition, You may apply to the Department for an expedited review of Your case. If accepted, the Independent Medical Review Organization will render a decision in three days.

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

California Department of Insurance
Claims Service Bureau, Attn: IMR
300 South Spring Street
Los Angeles, CA 90013
Or fax to 213-897-5891

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific Policy provisions on which the decision is based; (3) 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; (4) 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.

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.

Arbitration

CIGNA uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of services under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute or medical malpractice, relating to the deliver of service under the plan, and to any claims in tort, contract or otherwise, between individual(s) seeking service under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and CIGNA (including any of their agents, successors or predecessors-in-interest, employees or providers.)

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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.

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 31 days 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.