Connecticut General Life Insurance Company

INDIVIDUAL PLAN

GEORGIA HEALTH SAVINGS 3500

OUTLINE OF COVERAGE

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

A. Coverage is provided by Connecticut General Life Insurance Company (referred to herein as "CIGNA"), an insurance company that provides participating provider benefits.

B. To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Connecticut General Life Insurance Company
Individual Services – Georgia
P.O. Box 30365
Tampa FL 33630-3365
1-877-484-5967

C. A **Preferred Provider Plan** enables the Insured to incur lower medical costs by using providers in the CIGNA network.

A **Participating Provider** (Preferred 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 **Non-Participating Provider** (Non-Preferred Provider) is a Provider who does not have a Participating Provider agreement in effect with CIGNA. 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.

D. Covered Services and Benefits

Deductibles

- The **Individual In-Network Deductible** applies if You have an individual plan and 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 per 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. Any Covered Expenses incurred from October through December that are applied toward the Individual In-Network Deductible for that calendar Year will also be applied toward the Individual In-Network Deductible for the next calendar Year.

- The **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 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. Any Covered Expenses incurred from October through December that are applied toward the Family In-Network Deductible for that calendar Year will also be applied toward the Family In-Network Deductible for the next calendar Year.

- The **Individual Out-of-Network Deductible** applies if you have an individual plan and 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 per 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. Any Covered Expenses incurred from October through December that are applied toward the Individual Out-of-Network Deductible for that calendar Year will also be applied toward the Individual Out-of-Network Deductible for the next calendar Year.

- The **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 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. Any Covered Expenses incurred from October through December that are applied toward the Family Out-of-Network Deductible for that calendar Year will also be applied toward the Family Out-of-Network Deductible for the next calendar Year.

Out of Pocket Maximum (s):

- The **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 for medical or pharmacy services for Participating Providers for Covered Expenses incurred during the remainder of that Year. 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. It also includes Coinsurance for medical and pharmacy 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.

- The **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 for medical or pharmacy services for Non-Participating Providers for Covered Expenses incurred during the remainder of that Year. 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. It also includes Coinsurance for medical or pharmacy 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.

- The **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 for medical or pharmacy services for Participating Providers for Covered Expenses incurred for the remainder of the Year. 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.

- 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 You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Non-Participating Providers for Covered Expenses incurred for the remainder of the Year. 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.

We will NOT apply Deductibles, or Coinsurance paid to Non-Participating Providers toward the Out of Pocket Maximums for Participating Providers. In addition, Deductibles, or Coinsurance paid to Participating Providers will NOT be applied toward the Out of Pocket Maximums for Non-Participating Providers.

BENEFIT SCHEDULE

The benefits outlined in the table below show the payment percentages for Covered Expenses **AFTER** any applicable Deductibles have been satisfied unless otherwise stated.

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge unless otherwise noted)
Medical Benefits		
Annual Deductible *Individual* *Family*	**In-Network Deductible** $3,500 $7,000	**Out-of-Network Deductible** $7,000 $14,000
Out-of-Pocket Maximum *Individual* *Family*	**In-Network Out-of-Pocket Maximum** $3,500 $7,000 Excluding Penalties and Policy Maximums	**Out-of-Network Out-of-Pocket Maximum** $10,500 $21,000 Excluding Penalties and Policy Maximums
Coinsurance	CIGNA pays 100% of eligible charges. You and Your Family Members pay 0% of Charges after the Policy Deductible.	CIGNA pays 70% of eligible charges. You and Your Family Members pay 30% after the Policy Deductible.
Prior Authorization Program **Prior Authorization – Inpatient** Please refer to the section on Prior Authorization of inpatient services for more information. **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 inpatient admissions; or You may be subject to a $500, penalty for non-compliance. 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 inpatient admission; subject to $500, 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	Unlimited	
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

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge unless otherwise noted)
Preventive Care **All Preventive Well Care Services** Please refer to "Comprehensive Benefits, What the Policy Pays For" section of this Policy for additional details	100% with Deductible waived	70% with Deductible waived
Physician Services ***Primary Care Physician (PCP) Office Visit*** ***Specialty Physician Office Visit*** *Consultant and Referral Physician Services* ***Surgeon, Anesthesia, Radiation Therapy, In-hospital visits, diagnostic x-ray and lab***	100% 100% 100%	70% 70% 70%
Hospital Services **Inpatient Hospital Services** **Emergency Admissions** ***Please note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	100% 100%	70% 100% based on the CIGNA contract allowance until transferable to a Participating Hospital then 70%
Outpatient Diagnostic and Free-Standing Outpatient Surgical Facility Services ***Please note:*** *Prior Authorization from CIGNA is required for specified outpatient surgeries and diagnostic procedures*	100%	70%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge unless otherwise noted)
Emergency Services		
Emergency Room	100%	100% based on the CIGNA contract allowance, if true emergency otherwise 70%
Ambulance *includes emergency transportation to the nearest facility only.*	100%	100% based on the CIGNA contract allowance, if true emergency otherwise 70%
Urgent Care	100%	100% based on the CIGNA contract allowance, if true emergency otherwise 70%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) ***Please note:*** *Prior Authorization from CIGNA is required for specified diagnostic procedures*	100%	70%
All Other Laboratory and Radiology Services		
Physician's Office	100%	70%
Independent Facility	100%	70%
Outpatient hospital facility	100%	70%
Physical, Occupational & Speech Therapy 24 visits maximum per Insured Person, per calendar year for all therapies combined In and Out of Network.	100%	70%
Cardiac & Pulmonary Rehabilitation	100%	70%
Dental Care		
For accidental injury to natural teeth, within 6 months of the date of injury	100%	70%
Anesthesia for dental procedures for a dependent child (up to age 7 or developmentally disabled)	100%	70%
Complications of Pregnancy	100%	70%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge unless otherwise noted)
Inpatient Services at Other Health Care Facilities, Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities *30 day maximum per Insured Person, per calendar year combined for all facilities listed, In and Out of Network combined.* ***Please note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	100%	70%
Home Health Services *60 visit maximum per Insured Person, per calendar year.* ***Please note:*** *Prior Authorization from CIGNA is required for all Durable Medical Equipment*	100%	70%
Durable Medical Equipment ***Please note:*** *Prior Authorization from CIGNA is required for all Durable Medical Equipment*	100%	70%
Hospice ***Please note:*** *Prior Authorization from CIGNA is required for all Hospice Services*	100%	70%
Mental, Emotional or Functional Nervous Disorders ***Inpatien****t- 30* days maximum combined in and out of network per Insured Person, per Calendar Year for inpatient Mental Health ***Please note:*** *Prior Authorization from CIGNA is required for all Inpatient Services* ***Outpatient*** – 48 visits combined in and out of network maximum per Insured Person, per calendar year for outpatient Mental Health	100% 100%	70% 70%

BENEFIT INFORMATION	IN-NETWORK (Based on CIGNA contract allowance)	OUT-OF-NETWORK (Based on Maximum Reimbursable Charge unless otherwise noted)
Organ and Tissue Transplants- *(see benefit detail for covered procedures and other benefit limits which may apply.)*		
CIGNA LIFESOURCE Transplant Network® Facility	100%	70%
Other CIGNA Network Facility Contracted to Provide Transplant Benefits ***Please note:*** *Prior Authorization from CIGNA is required for all Inpatient Services*	100%	*NOT APPLICABLE*
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 & OUT-OF-NETWORK (Based on CIGNA contract allowance)
Prescription Drugs Benefits **Note: Includes Prescribed contraceptive services and devices** ***CIGNA Pharmacy Retail Drug Program***	
Generic drugs*- on the Prescription Drug List for a 30-day supply*	CIGNA Pays 100%
Brand Name drugs designated as preferred*- on the Prescription Drug List with no Generic equivalent for a 30- day supply*	CIGNA Pays 100%
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred*- on the Prescription Drug List for a 30- day supply*	CIGNA Pays 100%
Self-administered injectables	CIGNA Pays 100%
CIGNA Tel-Drug Mail Order Drug Program	
Generic drugs*- on the Prescription Drug List for a 90-day supply*	CIGNA Pays 100%
Brand Name drugs designated as preferred*- on the Prescription Drug List with no Generic equivalent for a 90-day supply*	CIGNA Pays 100%
Brand Name drugs with a Generic equivalent and drugs designated as non-preferred*- on the Prescription Drug List for a 90-day supply*	CIGNA Pays 100%
Self-administered injectables	CIGNA Pays 100%

E. Emergency Services and Benefits

CIGNA is obligated to provide reimbursement for emergency care at the Participating Provider level if the Insured Person cannot reasonably reach a Participating Provider and until the Insured Person can reasonably be expected to transfer to a Participating Provider.

The emergency care services subject to this section include:

1. any medical screening examination or evaluation required by state or federal law to be provided in the emergency department of a Hospital necessary to determine whether a medical emergency exists;
2. necessary emergency care services including the treatment and stabilization of an Emergency Medical Condition; and
3. services originating in a Hospital emergency department following treatment or stabilization of an Emergency Medical Condition.

F. Insured's Financial Responsibility

The Insured is responsible for paying the monthly or quarterly premium on a timely basis. The Insured is also responsible to pay Providers for charges that are applied to the Deductibles, Coinsurance, Penalties and any amounts charged by Non-Participating Providers in excess of the Maximum Reimbursable Charges. In addition, any charges for Medically Necessary items that are excluded under this Policy are the responsibility of the Insured.

G. Exclusions, Limitations, and Reductions

1. The Participating Provider Plan does not provide benefits for:

● **Conditions which are Pre-existing as defined.** ● Any **amounts in excess of maximum amounts of Covered Expenses**. ● Services or supplies **not specifically listed as covered in the Benefits section**. ● Services or supplies that are **not Medically Necessary**. ● Services or supplies that CIGNA considers to be for **Experimental Procedures or Investigative Procedures,** except as listed in the Benefits section. ● Services received **before the Effective Date** of coverage. ● Services received **after coverage ends unless provided under Continuation**. ● Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have a health plan or insurance coverage.● Any condition for which benefits are covered under any **workers' compensation**, 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 Medicaid),** except when payment under the Policy is expressly required by federal or state law. ● **Non-Duplication of Medicare:** Any services for which Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency. Veteran's Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation ● 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. ● 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 the 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 ●

Treatment of substance abuse. ● **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 the 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 the 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). ● **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 gynecomatia 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. ● **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, craniosacral/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 treatment of **fertility and/or Infertility**, including, but not limited to, all tests, examinations, except for tests and examinations required for the diagnosis of infertility, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, except as specifically stated in this Plan. ● 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 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 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, swimming pools, elevators and supplies for hygiene or beautification, including wigs etc.). ● **Educational services** except for diabetes self-management training and as specifically provided or arranged by CIGNA. ● **Nutritional counseling** or food supplements, except as specifically listed in the Policy. ● **Durable Medical Equipment** not meeting the criteria listed in the covered expense section of the 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; swimming pools, 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 the 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 under the Benefits section of the 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 pairing and removing of corns or calluses or the trimming of nails. ● **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 stand-by 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 the Policy. ● Claims received by CIGNA after 15 months from the date service was rendered, except in the event of a legal incapacity.

The Preferred Provider Plan does not provide Prescription Drug Benefits for:

- drugs available over the counter that do not require a prescription by federal or state law other than insulin;
- 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;
- 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;

2. Pre-existing Condition Periods

Any services received by an Insured Person age 19 and older 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.

The exclusion for Pre-existing Conditions does not apply to an Insured Person under age 19. This exclusion also does not apply to an Insured Person age 19 and 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 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 age 19 and older 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 Plan. Proof of Creditable Coverage is required.

3. Penalties

May apply in the following circumstances:

- Services for Inpatient Hospital, Skilled Nursing facilities, Extended Care facilities, Organ/Tissue Transplants, and Hospice Care without a Prior Authorization may be subject to a **$500** Penalty.
- Free-Standing Outpatient Surgical Facility Services without a Prior Authorization may result in a **$60** Penalty.
- Specified outpatient surgeries and diagnostic procedures without Prior Authorization. May result in a **$60** Penalty.
- Services for Home Health and Durable Medical Equipment without Prior Authorization may result in a **$60** Penalty.

H. 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. To verify Prior Authorization requirements for inpatient services, 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.

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.

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services required 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 for Certain Prescription Drugs

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.

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.

I. Continuity of Care

- 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 that 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.

J. Complaint Resolution Procedures

WHEN YOU HAVE A COMPLAINT OR AN ADVERSE DETERMINATION 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.

When You Have a Complaint

We are here to listen and help. If an Insured Person has a complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, they can call Our toll-free number, which appears on the Benefit Identification card, explanation of benefits, or claim form, and explain the concern to one of our Customer Service representatives. A complaint does not include: (a) a misunderstanding or problem of misinformation that can be promptly resolved by CIGNA by clearing up the misunderstanding or supplying the correct information to the Insured person's satisfaction; or (b) the Insured Person and their provider's dissatisfaction or disagreement with an adverse determination. We will do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your complaint, We will send a one page letter acknowledging the issue and the date on which We received the complaint no later than the fifth working day after We receive the complaint.

The Insured Person can also express that complaint in writing. Please write to Us at the 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 complaint, We will send a one page letter acknowledging the issue and the date on which We received the complaint no later than the fifth working day after We receive the complaint. We will respond in writing with a decision 30 calendar days after We receive a complaint for a post service coverage determination. If more time or information is needed to make the determination, We will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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 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. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, We will respond orally with a decision no later than one hour from the request, and followed up in writing within 3 calendar days.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, the Insured Person must submit a request for an appeal in writing. 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 or write to Us at the toll-free number or address on the Benefit Identification card, explanation of benefits or claim form.

The complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. 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. 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. 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. 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 no later than one hour from the request, and followed up in writing within three calendar days.

When You have an Adverse Determination Appeal

An Adverse Determination is a decision made by CIGNA that the health care service(s) furnished or proposed to be furnished to the Insured Person is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by CIGNA of a request to cover a specific prescription drug prescribed by the Physician. If an Insured Person is not satisfied with the Adverse Determination, he or she may appeal the Adverse Determination orally or in writing. The Insured Person should state the reason why he or she feels the appeal should be approved and include any information supporting the appeal. We will acknowledge the appeal in writing within five working days after We receive the Adverse Determination Appeal request.

The appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

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. 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 no later than one hour from the request, and followed up in writing within three calendar days.

An Insured Person or their health care provider may also request to appeal an Adverse Determination regarding a retrospective review in the same manner as all other Adverse Determination appeals.

In addition, the treating Physician may request in writing a specialty review within 10 working days of Our written decision. The specialty review will be conducted by a Physician in the same or similar specialty as

the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination they must provide the Insured Person's health care provider, who ordered the services, a reasonable opportunity to discuss the Insured Person's treatment plan and the clinical basis for the specialty reviewer's determination with a health care provider who is of the same specialty as the specialty reviewer. If the Insured Person remains dissatisfied, he or she is still eligible to request a review by an Independent Review Organization.

Independent Review Procedure

If the Insured Person is not fully satisfied with the decision of CIGNA's Adverse Determination appeal process or if they feel the condition is life-threatening, they may request that their appeal be referred to an Independent Review Organization. In the case of life-threatening conditions the Insured Person is entitled to an immediate appeal to an Independent Review Organization and will not be required to comply with the internal review process for Adverse Determinations, subject to the conditions listed below. In addition, your treating Physician may request in writing that CIGNA conduct a specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by 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 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 initiate this independent review process and the decision to use the process is voluntary. 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 cost of the service must be $500 or more; and

The reason for denial must be based on a Medical Necessity adverse determination and You must have exhausted the above Appeals procedures; or

the proposed treatment is excluded as experimental, and (1) you have a terminal condition with a substantial probability of causing death within two years or impairing your ability to regain or maintain maximum function; (2) the standard treatments have been exhausted and the treating Physician certifies that there is no standard treatment available under this certificate more beneficial than the proposed treatment; (3) the treating Physician has certified in writing the treatment is likely to be more beneficial than any available standard treatment; and (4) the treating Physician has certified in writing that scientifically valid studies demonstrate that the proposed treatment is likely to be more beneficial to You than available standard treatment. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must complete the written request form and forward it to the Georgia state planning agency. The planning agency will select an Independent Review Organization to review the issue and the Independent Review Organization will make a determination that is binding upon CIGNA.

The Independent Review Organization will render an opinion within 15 working days following receipt of all necessary information. When requested and when a delay would be detrimental to your condition, as determined by the treating health care provider, the review shall be completed within 36 hours of receipt of all necessary information.

You will receive detailed information on how to request an Independent Review and the required forms You will need to complete with every Adverse Determination notice.

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

Appeal to the State of Georgia

You have the right to contact the Georgia Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Georgia Department of Insurance may be contacted at the following address and telephone number:

Georgia Department of Insurance
2 Martin Luther King, Jr. Drive
Floyd Memorial Bldg, 716 West Tower
Atlanta, GA 30334
404-656-2070

Georgia Dept. of Human Resources
Two Peachtree Street, NW
Suite 33.250
Atlanta, GA 30303-3167
404-657-5550

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.

Dispute Resolution

All complaints or disputes relating to coverage under this Policy may 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.

K. Participating Providers

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

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

L. Renewability, Eligibility, and Continuation

1. The Policy will renew except for the specific events stated in the Policy. CIGNA may change the premiums of the Policy after 60 days' written notice to the Insured. However, CIGNA will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.
2. The Individual Plan Georgia Health Savings is designed for residents of Georgia who are not enrolled under or covered by any other group or individual health coverage. You must notify CIGNA of all changes that may affect any Insured Person's eligibility under the Policy.
3. You or Your Insured Family Members will become ineligible for coverage:
   a. When premiums are not paid according to the due dates and grace periods described in the Premium section of the Policy.
   b. When the Insured's spouse is no longer married to the Insured.
   c. When the Insured Person no longer meets eligibility requirements as an eligible Family Member.
   d. The date the Policy terminates.
4. 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.

M. Premium

1. The initial premium for the Policy for which you have made application is $_____ for _____ months. Premiums thereafter are payable quarterly by check or monthly through automatic bank draft withdrawals. The initial premium amount must be submitted with your original application.
2. The premium rates for this Policy are based on the age, place of residence, and the number and relationship of the Insured's Family Member(s) covered by the Policy. Changes in these factors may result in a change in premium.
   a. The rate provided to You is for the residence shown in your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.
   b. CIGNA also has the right to change premiums after 60 days' notice to you.