Supplemental Benefits Agent Guide

For agent use only.

952832e 11/23

At Cigna Healthcare, we believe that being true to yourself is the first step to being truly healthy.

That's how we run a healthy business, holding fast to our health service mission. That's how we generate value for our shareholders, staying true to our global growth strategy. That's how we attract the best employees, offering them ways to contribute their unique talents.

And that's how we serve our customers, encouraging them to go forward to the beat of their own drummer.

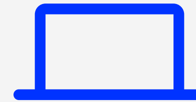
We are a global health service company with over 227 years in the insurance business. We maintain sales capability internationally in 30 countries and jurisdictions, with approximately 86 million customer relationships worldwide, and we are dedicated to improving the health and vitality of those we serve.

Our Supplemental Benefits insurance plans offer solutions that help individuals and their families do just that. Our portfolio helps support the supplemental health and senior markets by offering the following solutions through Cigna Health and Life Insurance Company (CHLIC), Cigna National Health Insurance Company (CNHIC), or Loyal American Life (LOYAL) insurance companies.

- Medicare Supplement
- Whole Life Insurance
- Dental, Vision & Hearing
- Cancer
- Heart Attack & Stroke
- Hospital Indemnity
- Accident

In the following pages, you will find the information you need to provide the quality and service your customers expect from Cigna Healthcare℠. From products to technology, we have what you need to build your business. Submit error-free applications electronically with Express App, get quotes on your mobile device and stay up to date with our virtual office, **CignaforBrokers**.

We are here to help you reach your full potential.



CignaforBrokers.com is your virtual home office. Here, you will find the most up-to-date forms for your state, in addition to:

- **Express App**
- **Commissions**
- **Product availability**
- **Agent training**
- **Customer information**
- **Brochures and application packets**
- **Production reports**
- **News and notices**

Visit CignaforBrokers.com to access all that we have to offer you.

Medicare Supplement policies 1
Introduction to Medicare Supplement Insurance plans 2
Medicare Access and CHIP Reauthorization Act (MACRA) 3
The sales process 3
Understanding the application 4
Completing the application 6
Underwriting guidelines 7
Premium calculations and payments 9
Customer programs and value-added services 10

Flexible Choice Dental, Vision & Hearing 12
Introduction to Flexible Choice Dental, Vision & Hearing 13
Coverage types 14
Plan options 14
The sales process 15

Individual Whole Life 16
Introduction to Individual Whole Life 17
Coverage types 17
Optional rider 18
The sales process 18
Anti-money laundering (AML) training 18
Premium calculations and payments 19
Underwriting guidelines 19

Flexible Choice Cancer and Heart Attack & Stroke 21
Introduction to Flexible Choice Cancer and Heart Attack & Stroke 22
Cancer 22
Heart Attack & Stroke 22
Coverage types 23
The sales process 23
Optional benefits 24
Adding riders after an initial policy sale 25
Underwriting guidelines 26

Flexible Choice Hospital Indemnity 28
Introduction to Hospital Indemnity 29
Coverage types 29
The sales process 30
Rates 30
Optional benefits 30
Underwriting guidelines 32

Cancer Treatment 33
Introduction to Cancer Treatment 34
Coverage types 34
The sales process 34
Rates 35
Optional benefits 35
Underwriting guidelines 36
Riders 36

Choice Accident 38
Introduction to Choice Accident 39
Coverage types 39
The sales process 39
Rates 40
Optional benefits 40

Accident Treatment 42
Introduction to Accident Treatment 43
Coverage types 43
The sales process 43
Rates 44
Optional benefits 44
Underwriting guidelines 45

General information 47
General information 48
Additional underwriting 49
Express App 50
eSignature 51
FaxApp program 52
Phone Verification (PV) 52
Steps to submitting a phone sale 53
New business processing 53
Customer service 54
Bank draft/auto-pay 56
Commissions 56
Agent services 57
Group/association 58
Group/association setup form 60
Payroll deduction form 62
FaxApp cover sheet 63
Height and weight charts 64
Tables and charts 66

Appendices 68
Appendix A: Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Healthcare Supplemental Benefits. 69
Appendix B: Contact list 72

Medicare Supplement policies

Coverage for Part A and Part B expenses not covered by Medicare

952832e 11/23

Introduction to Medicare Supplement Insurance plans

A Medicare Supplement (or Medigap) Insurance policy is an individual supplemental health insurance plan that provides benefits for all or part of the deductible and coinsurance amounts not covered by Medicare. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) permits issuance of a Medicare Supplement policy to individuals who have other health insurance plans, such as long-term care, specified disease or hospital indemnity policies. However, it is unlawful to sell a Medicare Supplement policy to an individual who already has a Medicare Supplement policy, unless the new policy will replace the existing policy. Additionally, it is unlawful to sell a Medicare Supplement policy to an individual who already has a Medicare Advantage policy, unless the new policy will replace the existing policy.

Benefit chart of Medicare Supplement plans sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare Supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and high-deductible F.

	Plans available to all applicants ✓ means 100% of the benefit is paid								Medicare first eligible before 2020 only	
Benefits	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copay	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply[2]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copay	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					\$6,940[3]	\$3,470[3]				

1. Plans F and G also have a high-deductible option, which requires first paying a plan deductible of \$2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High-deductible plan G does not cover the Medicare Part B deductible. However, high-deductible plans F and G count our payment of the Medicare Part B deductible toward meeting the plan deductible.
2. Plan N pays 100% of the Part B coinsurance, except for the copay of up to \$20 for some office visits and up to a \$50 copay for emergency room visits that do not result in an inpatient admission.
3. Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

Medicare Access and CHIP Reauthorization Act (MACRA)

This act prohibits first-dollar, Medicare Part B deductible coverage on Medicare Supplement plans.

- Plans C and F are the only plans that have first-dollar coverage. Plans C and F cannot be sold to those newly eligible to Medicare on or after January 1, 2020.
- A customer is newly eligible if they turned age 65 on or after January 1, 2020, and first become Medicare eligible on or after that date. If an individual becomes Medicare eligible before January 1, 2020, based on disability or end-stage renal disease (ESRD) status, or turns age 65 before January 1, 2020, whether eligible for Medicare on that date or not, they would be eligible to buy a Plan C or F when they are entitled to Medicare Part A and enrolled in Part B.
- This prohibition applies to all states, including waiver states.
- Elimination of Plans C and F for newly eligible Medicare beneficiaries makes Plans D and G the new guarantee issue (GI) plans for newly eligible Medicare beneficiaries within the current guarantee acceptance rules of Medicare Supplement plans.
- Those Medicare beneficiaries who purchased Plan C or F prior to January 1, 2020, can keep their plan.
- Plans C and F can still be sold after January 1, 2020, but only to Medicare beneficiaries who were age 65 prior to January 1, 2020, or first became eligible for Medicare prior to January 1, 2020. This is irrespective of what plan they previously had. For example, a customer who bought Plan C in 2018 can purchase any plan, including C or F, prior to January 1, 2020, or thereafter.

Eligible prior to 01/01/2020	Eligible on or after 01/01/2020
Plan C	Plan D (which is Plan C without Part B deductible coverage)
Plan F	Plan G (which is Plan F without Part B deductible coverage)
Plan F High Deductible	Plan G High Deductible (which is High-Deductible Plan F without Part B deductible coverage)

The sales process

Sales tools

- Outline of Coverage
- Brochure (optional)
- Value-added services brochure (optional)
- Application packet
- myCigna.com®

Leave-behind materials

Here is a list of marketing materials every agent should have when completing a sale. Some of these materials are required by your state.

- Outline of Coverage for state (required)
- Brochure (optional)
- Value-added services brochure (optional)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (required)
- Replacement form, contained in application packet, if replacement policy (required)
- Any other state-specific forms included in your application packet to be left with applicant (required)

For agents in Maine only

No producer, agent or broker in the state of Maine may engage in any trade practice which is determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. This includes the solicitation of Cigna

Healthcare Supplemental Benefits Medicare Supplement products, including riders.

To reinforce the Maine Insurance Regulation and requirements, we will, at least annually, provide a reminder notification to contracted producers, agents and brokers addressing the use and distribution of company-approved marketing materials and product information to consumers.

The new policy

Policy
Check to ensure that the issued policy matches the requested policy.

Policy ID card
For your customer's use when purchasing health care services. A permanent laminated card will follow the delivery of the policy.

Delivery receipt
In states where required, the insured is to sign the delivery receipt and return it to the administrative office.

Rates
There is an initial 12-month rate guarantee. Rate increases to each respective customer will be separated by at least 12 months.

Alternate plans
Your customer's policy may not be issued as applied for. If a different underwriting class is approved, a notice will be sent to you and the application will be held for five calendar days, giving the applicant the opportunity to accept or decline the offer. If the offer is accepted, written notice must be signed by the customer and returned. The customer may call our Agent Resource department and provide verbal authorization to accept the different underwriting class and a different premium. Failure to comply will result in an automatic termination of the policy. If the offer is declined, the policy is terminated as not taken.

Understanding the application

Outside open enrollment, excluding guaranteed issue

- A completed application should be submitted. Health questions should be answered.
- Cigna Healthcare will underwrite the application. Underwriting can include a claims check, a prescription databases check, and an eSignature or a Phone Verification (PV) is required. See "Phone Verification" on page 52. Note: Using eSignature provides a faster underwriting process. See "eSignature" on page 51.

During open enrollment

- The Medicare Supplement open enrollment (OE) period lasts six months. OE generally starts on the first day of the month in which the applicant is both age 65 or older *and* enrolled in Medicare Part B. Check with your state for any additional OE periods.
- A completed application should be submitted. No questions in the Medical Questions section should be answered. See "Medical questions when submitting OE/GI applications" on page 7.
- All plans for sale in the state of residence will be available.

OE/GI quoting rules for certain plans[4]

Refer to GI guidelines in the current CMS guide entitled *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.*

Tobacco usage

For attained age and issue age, during OE and GI, plans should be quoted at the Preferred rate for the applicant's age, regardless of tobacco use. In Florida and Minnesota, regardless of OE or GI, plans should be quoted based on the applicant's age and tobacco usage, using the Tobacco and Nontobacco rates.

Disabled applicants under age 65

Applicants who are under age 65 and are disabled, according to Medicare qualification criteria, are generally not offered coverage unless an offer is mandated by the state in which they live. Refer to *Medicare & You*, the official government handbook, for details and updated state guidelines, which is available online at **www.medicare.gov**. Applications must be mailed or faxed with a wet signature.

Disenrollments/GI

If the applicant loses health coverage under certain circumstances, they will have a guaranteed right to

4. Check your state's Outline of Coverage for available plans.

purchase select Medicare Supplement plans offered by the company in the applicant's state.[4] They must apply within 63 calendar days following initial notification of loss of coverage or the actual date that coverage terminates. If the applicant applies after 63 calendar days, full underwriting will be required. Check for any other specific rules in the applicant's state. Once you have determined that guaranteed issue circumstances apply:

- Complete an application with the applicant.
- Submit a copy of the disenrollment/termination letter, including the policyholder's name and termination date by fax to **888.695.2591**. Be sure to include the policy number. Additional documentation may be required for certain guaranteed issue rights.
- No questions in the Medical Questions section should be answered. See "Medical questions when submitting OE/GI applications" on page 7.

Premium discounts

In some states, a premium discount is available to enrolling customers who reside with another adult, age 18 or older, which includes your legal spouse, civil union partner or domestic partner. We may request additional documentation to determine eligibility. Additionally, in some states, a premium discount is available when more than one member of a household enrolls, or is enrolled, in one of our Medicare Supplement plans. See the Outline of Coverage for details. *Make sure the applicant provides the name and Social Security number of the individual(s) living at their current address during the application process.*

- If a premium discount applies, then you should multiply the rate by the appropriate factor as indicated in the outline of coverage. For example, in South Carolina, a 6% premium discount is available when the applicant resides with another adult and an additional 14% (20% total) premium discount is available when the other adult enrolls or is enrolled in a Cigna Healthcare Medicare Supplement plan.
- "Household" is defined as a condominium unit, a single family home or an apartment unit within an apartment complex.
- Assisted living facilities, group homes, adult day care facilities, and nursing homes or any other health residential facility are not included in the definition of "Household."
- In most cases, if another member of the household has an affiliated[5] company Medicare Supplement plan, the policyholder will qualify the applicant for the discount. There are several states, including Alaska, Florida, Hawaii, New Hampshire, North Dakota and Washington, where a Medicare Supplement plan from an "affiliated" company will not qualify the customer for a discount. Agents should check the Outline of Coverage to confirm if the premium discount is available in their state.

Existing Cigna Healthcare Medicare Supplement policyholders eligible for the Household Discount will have the discount applied upon their next scheduled billing cycle when they notify us of their eligibility by:

- Ensuring any new Cigna Healthcare Medicare Supplemental policy applicant, residing in their same household, includes the existing policyholder's first and last name and Social Security number on their application; or
- Speaking to a customer service representative at **866.459.4272**; or
- Mailing notification of eligibility for the Household Discount (please include both policyholders' first and last name and Social Security number) to Cigna Healthcare at:

  Cigna Healthcare Supplemental Benefits
  PO Box 7525
  Scranton, PA 18505-5725

  New policyholders may request the Household Discount when they apply for their plan by including on their application the first and last name and Social Security number of the new or existing Cigna Healthcare Medicare Supplement policyholder residing in their same household.

5. Our current list of affiliated companies: American Retirement Life Insurance Company, Continental General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, Great American Life Insurance Company, Loyal American Life Insurance Company, Provident American Life and Health Insurance Company, and Sterling Life Insurance Company.

You may submit Medicare Supplement applications for customers who are turning 65 and who have not yet received their Medicare Beneficiary Identification (MBI) number – and a policy will be issued within standard timelines.

However, Cigna Healthcare will not pay claims made against a policy unless we have the MBI number on file.

Once the number is available, you or the customer may:

- Submit the MBI number directly to Cigna via phone, fax or USPS mail.
- Provide/have available the policy owner's name, date of birth, policy number and best contact number in the event that additional verification or details are needed.

Please allow up to 5–7 business days processing time.

- Phone: **866.459.4272**
- Fax: **888.670.0146**
- Mail: PO Box 5700, Scranton, PA 18505

Completing the application

All sections of the Medicare Supplement application must be completed. Make sure to refer to the application relevant to your state when reviewing this guide.

The following guidelines apply to all applications

- We accept Medicare Supplement applications for customers who are not current Medicare Supplement contract holders of companies insured or administered by Cigna Healthcare Supplemental Benefits: Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and Loyal American Life Insurance Company. Companies eligible for policy replacements are American Retirement Life Insurance Company, Cigna National Health Insurance Company, Loyal American Life Insurance Company, Sterling Life Insurance Company, Great American Life Insurance Company and United Teacher Associates Insurance Company.
- Both the issue state and the residence state must be based on the applicant. Agents must be licensed to sell Medicare Supplement in the applicant's state of residence, either by a state resident or nonresident license in order to take an application. Check your state's Outline of Coverage or our Product Availability Chart for availability. The mailing address state on the application must match the residence address state. All policies must be mailed and delivered in the issuance state.
- All agents must also use the current application packet for the insured's resident state at the time of application. Applications received for processing that are based on the agent's issue state and not the applicant's resident state will be returned.
- For UW and GI cases, the requested effective date may not be more than 90 days from the date the application was signed. For OE cases, the requested effective date may not be more than 180 days. In all cases, review state requirements; if they differ, they supersede the aforementioned effective dates.
- You should be sure to check all calculations against the premium rate charts and/or rate tools, including plan code, area rating, age, household discount, etc. Be sure to use the correct modal factor on the rate chart.
- With the exception of OE or GI applications submitted with a wet signature, additional underwriting is required. See "Underwriting Guidelines" on page 7.
- Payer/payee guidelines: Each policy is an individual contract. Premium payments will be accepted only from the policyholder or an immediate family member. No third-party payers will be accepted, except as noted. See "New business guidelines" on page 48.
- It is illegal to sell a Medicare Supplement plan to an individual with Medicaid except in certain situations. If the applicant answers "Yes" to question #2 in Section V of the application, then the Company can only sell them Medicare

Supplement coverage if one of the following conditions is true.

- Medicaid pays their Medicare Supplement premium.
- Medicaid pays all, or part of, the Medicare Part B premium.
- Their Medicaid coverage is ending prior to the Medicare Supplement requested effective date. If so, enter this information into the "Agent Notes" section under Section VII of the Medicare Supplement application.
- The individual losing Medicare resides in one of the following states and thus is eligible for GI within 63 days: CA, KS, ME, MT, OR, TN, TX, UT and WI.

For written applications

- Use black ink pen on all documents – no marker pens.
- Draw a line through any errors and have the applicant initial and date corrections. Do not use correction fluid or similar measures.
- Submit applications within 30 days of the signed application date; remember that applications cannot have a requested effective date prior to the date the application is signed.
- Submit an initial full modal premium or a signed Pre-Authorized Collection (PAC) form with all applications.
- Ensure the policy owner signs the application. If a power of attorney (POA) is used, proof of the POA will be required, along with the POA's signature on every page of the application. For more information regarding application requirements when using a POA, see "New business guidelines" on page 48. To find more about the "Express App", see "Express App" on page 50.
- Remember, we do not accept stamped signatures from either agents or applicants.
- If applicable, send all state-required forms (e.g., replacement, state disclosure and disenrollment/termination letter) with the application at the time of submission.
- Always submit a signed HIPAA authorization with the application.

Medical questions when submitting OE/GI applications

When submitting applications for OE and GI cases, please avoid answering or completing any questions in the Medical Questions section of the application. Any OE/GI applications that are submitted with any of the questions answered in the Medical Question section will require a new application.

Application submission options

- Online via Express App, our web-based application tool. See "Express App" on page 50.
- Fax via our FaxApp program. See "FaxApp program" on page 52.
- Standard mail, wet signature required.

Underwriting guidelines

All applications will be fully underwritten, unless the applicant qualifies for OE or GI. Our underwriting process includes eSignature or PV, prescription drug screening and a check with the Medical Information Bureau (MIB) if additional underwriting is required.

If an application is submitted as any rate class that does not meet our criteria the applicant and agent will be notified by letter of the alternate plan of coverage that is available (if applicable). A notice of premium due and approved rate class alternate schedule page will be sent with the policy, if applicant agrees to the terms. Standard II and III rate classes are not available to applicants under age 65. Normal underwriting rate classes and rules apply.

Preferred rate class (in FL, Nontobacco)

- All medical questions in Part A and Part B must be answered "No."
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-MS) for listed use only.
- The applicant's height and weight must be between the minimum weight and maximum weight found in our height and weight chart. See "Height and weight charts" on page 64.
- The applicant must not have any of the selected conditions listed. See "Selected conditions" on page 8. Not applicable in ID, MN, MI and OR.
- The applicant must not have used tobacco within the last 12 months.

Standard rate class (in FL, Tobacco)

- All medical questions in Part A and Part B must be answered "No," except for tobacco use.
- The applicant is not taking any of the drugs listed on our Declinable Drug List (CSB-9-0017-MS) for listed use only.
- The applicant's height and weight must be between the "Minimum weight" and "Maximum weight with selected conditions" found in our height and weight chart. See "Height and weight charts" on page 64.
- The applicant must not have any of the selected conditions listed in the next column. Not applicable in ID, MN, MI and OR.
- The applicant is a tobacco user or has used tobacco in the last 12 months.

Standard II rate class[6]

- All medical questions in Part A must be answered "No."
- The applicant is not taking any of the drugs listed as "Declinable" on the Declinable Drug List (CSB-9-0017-MS).
- Applicant answers "Yes" to any question in Part B of the Medical Questions (except for tobacco use) or is taking a drug listed in the Standard II or Standard III column of the declinable drug list that does not have an "X."
- The applicant's height and weight is outside the limits of the height and weight charts. See "Medicare Supplement" on page 64.
- The applicant has selected conditions, and their weight is outside the limits of height and weight with selected conditions. See "Medicare Supplement" on page 64.
- The applicant must not have used tobacco within the last 12 months.

Standard III rate class[6]

- Inclusive of Standard II rate class criteria.
- The applicant is a tobacco user or has used tobacco in the last 12 months.

Selected conditions

No longer declinable if Standard II or Standard III rates are available in your state.[6] Not applicable in ID, MN, MI and OR. Selected conditions include:

- Tobacco use,
- Diabetes, or
- Maintenance medications for heart and vascular conditions.

Applicants with one of the selected conditions whose weight is greater than the maximum weight in the "Maximum weight with selected conditions" column may qualify for the Standard II or Standard III class. Check your state's Outline of Coverage or our Product Availability chart *for availability.*

Cardiovascular conditions treatment and maintenance

Cardiovascular risks encompass a number of diseases and disorders, including heart attack, heart disease, coronary artery disease, carotid artery disease, peripheral vascular disease, congestive heart failure, cardiomyopathy, valvular heart disease, stroke, transient ischemic attack (TIA), angina and arrhythmias.

Guidelines for cardiovascular risks differ based on whether the condition is a one-time event (e.g., stroke, heart attack or surgery) or if the condition is treated on an ongoing basis.

- Treatment includes the use of medications to manage the new cardiovascular risk. Event or diagnosis is within two years of application date.
- Maintenance is when the event or diagnosis occurred more than two years ago and the customer has not taken three or more cardiovascular drugs within a 12-month period over the last two years and there has not been a new cardiovascular event/diagnosis or a change in heart medication or dosage in the past two years. Significant change could mean a change in medications, increase in dosage or new/additional medications.

Declinable drugs

Please make sure to reference our declinable drug list (DDL) during the application. Any drug listed on the application that is found on our DDL and used for the condition stated will be either declined or eligible for Substandard rate.

The medications that are being taken by the applicant are important considerations in the underwriting process. The medications listed in our DDL are used to treat significant health conditions/problems. Applicants taking these medications should not be submitted for our preferred/standard rates, but in some cases may qualify for our Standard II and

6. Standard II and III rate classes are not available in all states. Check your state's Outline of Coverage or our Product Availability Chart.

Standard III rates. The medications listed in our DDL are not intended to be an all-inclusive list of medications, as many of these medications have brand/generic forms and new medications are introduced regularly. Medications not listed in the DDL may still disqualify the applicant from coverage.

In addition, combinations of several medications may cause the applicant to be disqualified.

If you have an applicant taking any medication that gives you concern about insurability, please contact our underwriting team. In addition, if you have an applicant who is taking any of the listed medications for a reason other than that listed or is taking a combination of medications for a condition not listed, please contact our underwriting team for clarification.

Make sure to list all medications on the application. Always determine how the medication is used. Insurability is based on the conditions listed on the actual application.

If the applicant is currently taking, or has recently taken, a medication on our DDL for a use that is not listed on this application, we will require a signed and dated letter from the prescribing health care provider. This letter must state the condition for which the medication is being taken and must state that the applicant does not have the declinable condition on this list. Failure to include this letter with the application may lead to the declination of the application.

If necessary, the application may be placed in a hold status for no more than 10 days with a request to the applicant for the doctor statement, which would need to identify the reason the medication is/was being taken and state it is not for a declinable condition.

The Medicare Supplement business will be issued at the rate class requested by the agent. If the applicant does not qualify for the requested rate class, the next appropriate rate class will be applied.

All appeals require a signed and dated letter on letterhead from the treating/prescribing physician ruling out the declinable condition. For declines based on the medication taken, the letter must rule out the declinable condition and state the reason the medication was prescribed. Appeals should be faxed to **855.239.8763**, Attn: Underwriting. Please include assigned application number on the fax cover page. The underwriter will make the final determination in all cases.

Premium calculations and payments

One-time policy fee

Application fees do not apply in most states. Exceptions include a one-time $20 fee for each new Loyal DC and Loyal HI application.

Premium modes

Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill.

Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors. See "Medicare Supplement premium modes" on page 66.

Rate classes

Rate classes are Preferred (nontobacco user), Standard (tobacco user), Standard II (nontobacco user) and Standard III (tobacco user). In FL, they are nontobacco and tobacco. The Standard II and Standard III rate classes are not available in every state.

How to calculate premiums

If you are away from a computer or cannot access Express App, you can calculate the premiums manually using the instructions below.

- Determine the age of the insured by looking at the date the application was signed, not the requested date of coverage.
- Determine the correct rate area by using the first three digits of your customer's zip code.
- Decide which mode of premium payment you will use. Multiply the annual premium by the applicable factors to obtain the appropriate rate. *Example: $1,200 (annual premium) x 0.520 (semiannual) = $624 semiannual rate. For ID, MI, MN and OR, the rate is 0.085.*

- Household discounts vary by state. If applicable, multiply the premium by the factor listed in the Outline of Coverage Rate Chart footnotes.

Additional reference tools

The website for the Medicare program, www.medicare.gov, contains information regarding the program. It also contains the most popular publications listed below. You can view, print or order publications online or by calling **800.MEDICARE (800.633.4227)**. Some of these publications can be printed directly from the website.

- *Medicare & You*
- *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*
- *Your Medicare Benefits*

Many other publications also have valuable information. For example, the National Underwriter Company annually updates *All About Medicare*, its guide to the program.

Internal replacements

Internal replacements across the same company and from a plan with greater benefits to a plan with fewer benefits is GI, Plan F to Plan G excluded. Underwriting applies to all other internal replacement scenarios.

Customer programs and value-added services

Not all extra services are offered in all states; availability may vary. Customer programs cannot be used as an inducement to purchase a Medicare Supplement insurance policy. However, customer programs are allowed to be discussed or promoted during the sales process, if approved in the consumer brochure. Information is here for reference only should an agent receive a question from a policyholder. Please consult your state's Medicare Supplement consumer brochure for information, which can be shared at the time of sale.

Medicare Supplement customers receive full details and sign-up information with their new policy kit or value-added services brochure, mailed after the policy kit. Existing customers may contact customer service at **866.459.4272** to request full details.

Customer programs are not guaranteed insurance benefits with our Medicare Supplement insurance policies, and services may be added or discontinued. All customer programs are provided through third-party vendors and are not administered by any of our subsidiary companies.

Inside Rx[7]

This savings card helps self-pay customers lower their prescription drug costs on generic and non-featured brand medications. Visit **Insiderx.com/CSB** to download a card and save up to 80%[8] on medications. This card is free for customers and no enrollment necessary. Discounts on pet medications are available as well.

Health Information Line

Customers may utilize the Cigna Healthcare Health Information Line to speak one-on-one with a health advocate.[9] Health guidance and information are available 24/7/365. Customers may also listen to hundreds of helpful health topic recordings from the audio library.

Silver&Fit Exercise & Healthy Aging program[10]

Available only for ARLIC and LOYAL companies.

- Provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH); programs and services not available in all areas

7. Not available to customers issued a policy in Oregon; INSIDE RX PRESCRIPTION DISCOUNT CARD IS NOT INSURANCE. Cannot be used by persons covered by state or federal-funded programs such as Medicare, Medicaid or Tricare to purchase Inside Rx featured medications, even if processed outside the benefit as an uninsured (cash-paying) patient. Cannot be used with any insurance benefit or copay assistance programs. Inside Rx Pets card is only for use with prescriptions written and dispensed for animals at a participating pharmacy.
8. Average savings based on usage and Inside Rx data as compared to cash prices; average savings for all generics are 78%; 37% for select brand medications; restrictions apply.
9. Health advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing medical advice in any capacity as a health advocate.
10. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Silver&Fit and the Silver Slate are federally registered trademarks of ASH.

- Low-cost ($25 benefit year) access to a nationwide network of fitness clubs
- Group classes for older adults, where offered
- Low-cost ($10 per benefit year) option for at-home workouts utilizing up to 2 (per year) of the 15 available home fitness kits
- Digital healthy aging materials
- Newsletters four times a year
- Silver&Fit Connected!, a fun and easy way to track exercise at a facility or through a wearable fitness device or app and earn rewards. Rewards subject to change; purchase of device or app is not included
- Additional web tools, such as a facility search, health articles and challenges

Healthy Rewards[11]

This discount programs helps customers save on health and wellness services and supplies. Healthy Rewards programs are separate from medical benefits.

- Vision exams and eyewear – EyeMed
- Hearing aids and exams – Amplifon Hearing Health Care
- Alternative medicine – chiropractic, acupuncture, physical therapy and massage services

Weight and nutrition programs

- Save up to 25% on registered dietitian services – Meet with a food and nutrition expert who can tailor a plan to your specific medical and nutritional needs.
- Get free shipping on Mom's Meals – Enjoy refrigerated, affordable, home-delivered prepared meals that are tailored to your health needs.

The Active&Fit Direct Program[12]

Exclusive to CHLIC and CNHIC customers.

- Access over 12,000+ fitness centers nationwide and 9,300 workout videos for $28/month (plus a $28 enrollment fee and applicable taxes). Participating centers are part of American Specialty Health Networks and Choose Healthy.

USA Senior Care Network Premium Savings Program

USA Senior Care Network cannot be discussed pre-sale under any circumstances.

A policyholder may be eligible to receive a $100 credit off of a future premium payment should the policyholder have an inpatient stay at a participating USA Senior Care Network facility that requires payment of a Part A deductible. The network arrangement is nonrestrictive and has no impact on the policyholder's freedom to visit any provider who accepts Medicare. This program is purely a savings opportunity. Policyholders can verify availability and find hospitals that are part of USA Senior Care Network by calling USA Senior Care at **800.872.3860**.

This program is not available on Plan A and select Medicare Supplement Insurance plans. Please refer Medicare Supplement policyholders to their extra services brochure for more information.

11. Healthy Rewards programs are separate from Medicare Supplement insurance benefits. A discount program is NOT insurance, and the customer must pay the entire discounted charge. Some Healthy Rewards programs are not available in all states, and programs may be discontinued at any time. Participating providers are independent contractors who are solely responsible for any care or services provided.
12. Plus a $25 enrollment fee and applicable taxes. This is a discount program and is NOT insurance. This program is separate from your medical plan benefits. You are required to pay the entire discounted charge. ASH is an independent company/entity and is solely responsible for the Active&Fit Direct program. ASH is not an affiliate of Cigna Healthcare. Always consult your doctor prior to beginning a new exercise program. Your participation in this program may be subject to program terms and conditions and is at your sole risk. The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH).

Flexible Choice Dental, Vision & Hearing

Benefits to help your customers cover expenses from dental, vision and hearing services

952832e 11/23

Introduction to Flexible Choice Dental, Vision & Hearing

Our Flexible Choice Dental, Vision & Hearing product is designed for customers age 18 to 89 and includes benefits for dental, vision and hearing expenses. For all of these services, policyholders may see any provider of their choice. For dental services, policyholders can take advantage of pre-negotiated rates and discounts through Careington Maximum Care PPO's large national network of detail care providers.

Basic features

- Issue ages: 18–89.
- Renewability: Guaranteed renewable for life[13]
- Coverage for individuals, couples and families
- Eight available benefits in $500 increments that range from $1,000 to $4,000 and $5,000 per person (*Must be the same for all insured persons and all ages)*
- Low policy deductible options of $0, $50 or the maximum of $100 per policy year per person[14]
- A $100 disappearing deductible option may be selected at time of application; feature only available on a $100 deductible
- No annual policy fee

Additional information

- When a customer exhausts their policy benefits for the policy year, they can still see an in-network provider and will receive benefits at the pre-negotiated network rates.
- Most benefits increase over the first four years of coverage, per the chart below. In the fourth year, customers pay only 10% of the service fee out of pocket.[15]
- There is no annual spending limit and no restrictions on how many times members can use the discounts for the vision and hearing programs.[16]

Dental benefits	Plan pays
Class 1 (Preventive Services)	
Year 1	60%
Year 2	70%
Year 3	80%
Years 4+	90%
Class 2 (Basic Services)	
Year 1	60%
Year 2	70%
Year 3	80%
Years 4+	90%
Class 3 (Major Services)	
Waiting period: 12 months	
Year 1	0%
Years 2+	60%

Vision benefits	Plan pays
Waiting period: 6 months for all services	
Year 1	60%
Year 2	70%
Year 3	80%
Years 4+	90%

Hearing benefits	Plan pays
Waiting period: 12 months for all services	
Year 1	0%
Year 2	70%
Year 3	80%
Years 4+	90%

13. The policy cannot be terminated for any reason other than nonpayment of premium or material misrepresentation in the application for insurance; Subject to the company's right to increase premiums on a class basis
14. The deductible must be met before benefits are paid for any dental, vision or hearing treatment.
15. Excludes major restorative dental benefits, which remain at 60%.
16. Customers must use a provider within the national network in order to receive discounts on vision and hearing services.

Waiting periods

- The 12-month waiting period for Class 3 dental services is waived if the applicant is replacing dental coverage. When waived, major services are covered at 60% in year 1 and all remaining years.
- The vision waiting period of 6 months cannot be waived.
- The hearing waiting period of 12 months cannot be waived.

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse, and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

Plan options

Annual maximums

Customers have the ability to select one of eight options: $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000 and $5,000.

Deductibles

Customers have the ability to select one of four options: $0, $50, $100 and a $100 disappearing deductible.

Disappearing deductible
If selected, the policy's $100 annual deductible is reduced by a third each year, regardless of claim history. The disappearing deductible applies to the entire policy. Beginning in year 4, the customer's deductible is $0.

Year	Deductible
1	$100.00
2	$66.66
3	$33.33
4+	$0.00

Preventive care

- Ability to purchase 60%, 70%, 80% or 90% coverage in years 1/2/3/4+, with no waiting period
- Ability to purchase 100% coverage for all years
- No waiting period for preventive dental services

Waiving of waiting period

The waiting period for Class 3 dental services may be waived with proof of prior dental coverage or a Medicare Advantage plan that includes dental. Prior coverage must have been in force at least 12 months with a gap of no more than 60 days from the termination date. Prior dental coverage can remain active as it is not considered dual coverage.

If requesting a waiver after the policy is issued, the following should be submitted within 180 days on the plan provider's letterhead:

- Name of the plan provider
- Policy number
- Issue or effective date
- Termination date (if no longer active)

The sales process

Flexible Choice Dental, Vision & Hearing may be sold as a stand-alone policy and does not need to be sold along with a new policy or to an existing Cigna Healthcare Supplemental Benefits (CSB) customer.

Sales tools

- Outline of coverage
- Agent training flyer (optional)
- Brochure (optional)
- Customer scenario flyer (optional)
- **myCigna.com** for customer policy details once enrolled
- Application packet
- Rate booklet
- Express App

Marketing, sales or solicitations for any non-health-related insurance policies, i.e., life, accident or disability income, cannot be conducted if solely based on use of the HIPAA-protected health information of an insured person under a former or existing health policy.

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (*Effective date of the policy cannot be more than six months from the sign date of the application)*
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (if applicable)

The use of a Customer Booklet is required in all states. Visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

Rates

Premiums are based on issue age and banded for ages 18–49 and 50–89.

- Rates are unisex and uni-tobacco.
- Six modes of premium payment are available: annual, semiannual, quarterly, monthly, semi-monthly and bi-weekly. Monthly is available only via bank draft, and bi-weekly is only available on paper enrollment/application. All others are available via bank draft and direct bill.
- There is no policy fee or enrollment fee.
- Rates are guaranteed for the initial 12 months.
- For proper premium, the rates are based on the age of the oldest applicant.

Individual Whole Life

Benefits to help your customers protect their financial interests

952832e 11/23

Introduction to Individual Whole Life

Our Individual Whole Life Insurance policy is designed to help your customers prepare for a wide range of necessities and protect what is most important to them. Our Individual Whole Life policies feature guaranteed level premiums while accumulating cash value starting in the third year, and they can be accessed by either a policy loan or cash surrender.

Basic features

- Issue ages: 50–85
- Available benefit amounts: $2,000–$25,000 in $1,000 increments; may include other incremental benefit amounts, such as $2,500, $7,500 and $12,500.
- No annual policy fee
- Premiums will not increase
- 5% spousal premium discount[17]

Benefit plans

Two benefit plans, Level or Modified Benefit, allow coverage for a wide variety of health conditions. The Whole Life policy will be underwritten based on answers to the health questions on the application, which will determine the eligibility for the Level or Modified benefit. The Level Benefit Plan will pay the full death benefit amount to their chosen beneficiary upon their death. The Level Benefit Plan automatically includes a Terminal Illness Accelerated Benefit Rider. Should your customer be diagnosed with a terminal illness, they can request a percentage of the policy's death benefit, not to exceed 50%, in a lump sum benefit amount prior to death.[18]

The Modified Benefit Plan has adjusted levels of coverage for the first two years of the life of the policy, as shown in the chart below.[18]

The net cash value is payable if the insured is living at age 121. The policy may not qualify as life insurance after the insured has attained age 121 under federal tax law, and the policy may be subject to adverse tax consequences. A tax advisor should be consulted.

Loss of life	Death benefit amount
Accidental death while covered	100% of benefit
Non-accidental death within first two years of coverage	100% of premium paid + 10%
Non-accidental death after being covered for two or more years	100% of benefit

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

17. Only available if both individuals apply on the same application.
18. Subject to all terms and conditions of the policy and/or rider.

Optional rider

Accidental Death Benefit to Age 100 rider[19]

Form #ICC14-LY-ADBR

We offer our Accidental Death Benefit to Age 100 rider with death benefit amounts ranging from $10,000 to $50,000 for situations when death occurs within 180 days as a direct result of an accidental injury while covered under the policy and this rider is in force. If death from the accidental injury occurs after the rider terminates, this benefit is payable provided the accidental injury was sustained while the rider was in force and death occurs within 180 days of the injury.[20]

The sales process

Individual Whole Life may be sold as a stand-alone policy and does not need to be sold with a new Medicare Supplement policy or to an existing CSB Med Supp customer.

Sales tools

- Anti-money laundering (AML) training – Required prior to the sale of our Whole Life product. See "Anti-money laundering (AML) training" below.
- Agent Training Flyer optional
- Application packet
- Rate Booklet
- Express App

Marketing, sales or solicitations for any non-health-related insurance policies, i.e., life, accident or disability income, cannot be conducted if solely based on use of the HIPAA-protected health information of an insured person under a former or existing health policy.

Anti-money laundering (AML) training

Required training

If you're an agent selling life insurance products, you're required to take Anti-Money Laundering (AML) training. The course won't cost you anything. If you do not complete this training, we will not be able to process your customers' applications for Whole Life Insurance products, including cash-value riders on any insurance product. You may have completed similar training with other vendors or carriers; however, CSB requires that you complete the LIMRA courses as outlined below.

LIMRA training instructions

Visit https://aml.limra.com to access the course website. Your username is your National Producer Number (NPN).

If this is your first time accessing the course, your password is your last name in lowercase letters. You will then be prompted to change your password and enter your username in the spaces provided. The login function is case sensitive. If you have previously accessed the LIMRA site, please use the password created at that time.

Online help is available through the Forgot Your Password link if you do not remember your password. If you have any issues registering for AML, please email our Agent Licensing department at CSBLicensing@Cigna.com and allow up to 72 hours for a response.

Complete one of the following courses.

- Anti-Money Laundering for Insurance Producers. Complete this course if it is your first time completing an AML course through LIMRA.
- Fraud in Money Laundering – Anti-Money Laundering for Insurance Review. Complete this course if you've already taken the Anti-Money Laundering for Insurance Producers course through LIMRA. There are two versions of the course available, one with Flash enabled and one without. You are only required to complete one of these versions.

19. Rider available for an additional premium.
20. Subject to all terms and conditions of the policy and/or rider.

CSB will automatically receive notification of your course completion. You will not receive a certificate of completion. The home page indicates whether or not you have completed the assigned material.

Should you have technical questions accessing or navigating within the LIMRA site, please email LIMRA's technical support partner's help desk at **support@cfmpartners.com** or call **866.364.2380**.

See "Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Healthcare Supplemental Benefits (CSB)" on page 69.

Premium calculations and payments

Annual policy fee

There is no annual policy fee on the Individual Whole Life policy.

Premium modes

Four modes of premium payment are available: annual, semiannual, quarterly or monthly. Monthly is available only via bank draft. Quarterly, semiannual and annual are available via bank draft and direct bill.

Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors. See "Individual Whole Life premium modes" on page 66.

How to calculate premiums

If you are away from a computer or cannot access Express App, you can calculate the premiums manually using the instructions below.

- Determine the age of the insured by looking at the date the application was signed, not the requested date of coverage.
- Find the rates for modals not displayed, and multiply the annual rate by the modal factor listed below.

Spousal discount

If the applicant is on the same application as their spouse/domestic partner, a spousal discount of 5% can apply. Follow the instructions below to calculate the discounted rate.

For proper premium and rating for couples, the discounted spousal rate will always apply to the youngest applicant. Either spouse may be listed as the primary applicant; however, the discounted rate can only apply to the younger applicant. Entering the incorrect premium will result in processing delays and require submission of a new, corrected application.

Use the rate as displayed on rate chart for age, benefit level, etc. Multiply the rate that qualifies for the spousal discount by 0.95 (95%).

Example: $44.75 (listed rate) x .95 (spousal discount) = $42.51. This is the discounted rate you would enter on the application.

Underwriting guidelines

All applications will be fully underwritten. Our underwriting process includes a PV, an Rx Check Lookup, a DDL with applicable drugs obtained from Rx Check Lookup and a check with the Medical Information Bureau (MIB) if additional underwriting is required.

- Questions 1–7: "Yes" answer to any question will prevent CSB from issuing the policy.
- Questions 8–11: "Yes" answer to any question may result in Modified Benefit Plan coverage.
- "No" answer to all questions may result in Modified Benefit Plan coverage.
- The applicant is not taking any of the drugs listed on our DDL (CSB-9-0017-IWL) for listed use only. We will require a signed and dated letter from the

prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is not listed. This letter must state the condition for which the medication is being taken and must state that the applicant does not have the declinable condition on this list. Failure to include this letter with the application may lead to coverage being declined.

- When checking a customer's medications against the DDL (CSB-9-0017-IWL), always determine how that medication is used. Prescription medications may be used for multiple reasons. Insurability is based on the conditions listed on the actual application. Our underwriting department will have the final determination in all cases.

For Level Benefit Plan eligibility

- Customers must answer "No" to all questions in Section VII
- Congestive heart failure and cardiomyopathy are declinable conditions

For Modified Benefit Plan eligibility

- Can answer "Yes" to questions 8–11 in Section VII
- Diagnosed or treated for cancer (except basal cell carcinoma) one to four years before
- Within the past two years, diagnosed or treated for:
  - Emphysema
  - Chronic obstructive pulmonary disease (COPD)
  - Chronic bronchitis
  - Stroke or transient ischemic attack (TIA)
  - Multiple sclerosis (MS)
  - Parkinson's disease
  - Kidney disease other than infection or kidney stones
- Within the past 12 months, diagnosed, counseled or recommended to seek treatment for:
  - Alcoholism
  - Alcohol abuse
  - Drug or substance abuse treatment
- Diagnosed with or treated for diabetes before age 30 or complications from diabetes or diabetes requiring more than 50 units of insulin to control

All appeals require a signed and dated letter on letterhead from the treating/prescribing physician ruling out the declinable condition. For declines based on the medication taken, the letter must rule out the declinable condition and state the reason the medication was prescribed. Appeals should be faxed to **855.239.8763**, Attn: Underwriting. Please include assigned application number on the fax cover page. The underwriter will make the final determination in all cases.

Flexible Choice Cancer and Heart Attack & Stroke

Lump sum benefits to help cover expenses that come from cancer, heart attack, stroke or other heart-related conditions

952832e 11/23

Introduction to Flexible Choice Cancer and Heart Attack & Stroke

Basic features

- Issue ages: 18–99
- Available benefit amounts: $5,000–$75,000;[21] must be the same for all insured persons; see Underwriting Guidelines for any benefit amount over $50,000
- Renewability: Guaranteed renewable for life[22]
- Available riders, for an additional premium: Lump Sum Cancer, Cancer Recurrence, Lump Sum Cancer Benefit Builder, Radiation and Chemotherapy, Lump Sum Heart Attack & Stroke, Heart and Stroke Restoration, Lump Sum Heart and Stroke Benefit Builder, Hospital Indemnity, Intensive Care Unit Indemnity, Hospital and Intensive Care Unit Indemnity, Specified Disease, Accident Fixed Indemnity, and Return of Premium[23]

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Preexisting condition periods may vary by state. Refer to the Exclusions and Limitations in the brochure.

Cancer

Available as a rider on a Heart Attack & Stroke base policy.

Our Flexible Choice Cancer provides a lump sum benefit payable on diagnosis of any cancer. Benefit amounts, ranging from $5,000 to $75,000, are paid directly to the insured or their designee.

Reduction of benefits

There is a reduced benefit for the first 30 days immediately following the effective date of the policy and/or rider. If the insured is diagnosed with cancer or carcinoma in situ within the first 30 days, we will pay 10% of the benefit amount upon diagnosis of cancer. If this reduced benefit is paid, coverage for the insured under the policy will terminate.

Heart Attack & Stroke

Available as a rider on a Cancer base policy.

Our Flexible Choice Heart Attack & Stroke Insurance provides a lump-sum benefit payable on the diagnosis or procedure under the policy for any of the qualifying events. Benefit amounts, ranging from $5,000 to $75,000,[24] are paid directly to the insured or their designee. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for a qualifying event. See "Lump Sum Heart Attack & Stroke qualifying events benefit amount" on page 66.

Stroke

Stroke means an acute cerebral vascular accident (due to rupture or acute occlusion of a cerebral artery) producing neurological impairment and

21. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.
22. Subject to the company's right to increase premiums on a class basis.
23. Rider availability varies by state. Please check your policy in your state.
24. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.

resulting in paralysis or other measurable objective neurological deficit, positively diagnosed by a physician, persisting for at least 30 days. This definition of stroke shall specifically exclude transient ischemic attacks, attacks of vertebrobasilar ischemia, head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits. The diagnosis must be made by a physician who is a board-certified neurologist.

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (Effective date of the policy cannot be more than 90 days from the sign date of the application.)
- Pre–Authorized Agreement for EFT (Bank Draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (if applicable)

The use of a Customer Booklet is required in all states. Visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

For agents in Massachusetts only

The state of Massachusetts requires training for any agent selling specified disease insurance products. This would be any of Cigna Healthcare Supplemental Benefits Cancer and Heart Attack & Stroke products, including riders.

- Specified disease insurance products required training video and Attestation Form

Rates

- Premiums are based on issue age and banded for ages 18–29 and then in five-year age bands from 30 to 99.
- Rates are unisex and uni-tobacco.
- Rates are guaranteed for the initial 12 months.
- Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill. Direct bill is not available on a monthly basis. See "Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart and Hospital Indemnity premium modes" on page 67.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.

- Cancer Recurrence Benefit rider and Heart Attack & Stroke Restoration Benefit rider amount must match the corresponding base policy amount.
- There is no policy fee or enrollment fee.
- Minimum monthly premium amount is $8.
- To calculate the premium for any mode, multiply the monthly premium by the factor.

Optional benefits[25]

Radiation and Chemotherapy Benefit Rider

This rider is an affordable hybrid cancer policy option. The Radiation and Chemotherapy Benefit Rider pays for radiation and chemotherapy treatment. It may only be purchased with the Cancer Recurrence Rider. Please consult your outline of coverage for a full list of benefits.

Lump Sum Cancer and Heart Attack & Stroke Benefit Builder riders

These riders can be added to the Lump Sum Cancer policy and Heart Attack & Stroke policy to gradually increase the benefit amount over time. Each year, on the rider anniversary date, we will increase the policy benefit amount by $500 or $1,000 while the rider remains in force. This annual benefit amount will continue to build each year until the year-35 rider anniversary date.

The benefit builder riders only increase the base policy benefit amount, and once the base policy is exhausted (paid out 100% of benefits), benefits will cease to build. The benefit builder riders do not increase the value of other riders, such as Cancer Recurrence or Heart Restoration.

Specified Disease/Critical Illness

We will pay up to the customer's chosen lump sum benefit amount when a physician diagnoses them with one of the covered specified diseases.

- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS)
- Blindness
- Coma
- End-stage renal failure
- Loss of hearing
- Loss of speech
- Major organ transplant
- Multiple sclerosis (MS)
- Paralysis
- Severe burns

Benefits range from $5,000 to $50,000. Please consult your outline of coverage for a full list of benefits.

Accident Fixed Indemnity

This rider pays a fixed indemnity benefit when you suffer covered injuries in a covered accident. This rider also includes benefits for accidental death and dismemberment. Issue ages from 18 to 74, and guaranteed renewable until age 80.[26] Please consult your outline of coverage for a full list of benefits.

Cancer Recurrence Benefit rider

Only available on Cancer base policy.

This rider pays a percentage of the benefit amount upon additional diagnoses of cancer. The recurrence benefit applies when 100% of the base benefit amount has been paid and the insured has not received advice or treatment for cancer for at least 24 consecutive months from the date of the last diagnosis. Under this rider, the payable amount may not exceed an additional 100% of the benefit amount.

Available benefit amounts are between $5,000 and $75,000[26] and must be the same as the base benefit amount. Benefit choice must be the same for all insured persons.

Heart Attack & Stroke Restoration Benefit rider

Only available on Heart base policy.

This rider pays a percentage of the benefit amount upon additional diagnoses or procedures of heart attack, heart transplant or stroke as shown in the Heart Attack & Stroke base policy table. The

25. Rider availability varies by state. Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.
26. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.

Restoration Benefit applies when 100% of the original benefit has been paid and the customer has not received advice or treatment from a physician for these specific qualifying events for at least 24 months from the date of the last diagnosis or qualifying event. The customer will receive 25% of the benefit if they have not received treatment for 24 months to five years, 75% for 5 to 10 years and 100% after 10 years. See "Heart Attack & Stroke Restoration rider, and Lump Sum Cancer and Recurrence rider" on page 67.

Available benefit amounts are between $5,000 and $75,000[27] and must be the same as the base benefit amount. Benefit choice must be the same for all insured persons.

Return of Premium rider

This rider pays 100% of total premiums paid for the policy and any riders less claims paid upon the death of the primary insured.

Hospital Indemnity Benefit rider

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy, including confinement to the intensive care unit or coronary care unit. Benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Intensive Care Unit Indemnity Benefit rider

This rider provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the intensive care unit as an inpatient due to injury, sickness or complications of pregnancy. Benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Hospital and Intensive Care Unit Indemnity Benefit rider

Cannot be sold with the Hospital Indemnity rider or the Intensive Care Unit Indemnity rider.

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness or complications of pregnancy. Benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Adding riders after an initial policy sale[28]

If a policyholder has a Flexible Choice Cancer or Heart Attack & Stroke policy, they may apply to add certain riders to their policy. The following riders are permitted to be added to a policy:

- Accident Fixed Indemnity Benefit rider may be added to either the Lump Sum Cancer or Lump Sum Heart Attack & Stroke policies.
- Lump Sum Cancer Benefit Builder rider may be added to the Lump Sum Cancer policy.
- Lump Sum Heart Attack & Stroke Benefit Builder rider may be added to the Lump Sum Heart Attack & Stroke policy.

Process

Paper application
A paper application will need to be used to add riders; riders cannot be added in the enrollment system. On the application, select the checkbox for "Add Rider(s) to existing policy."

Underwriting
The applicant will need to go through the appropriate underwriting (health history questions) to add riders.

Accident Fixed Indemnity Benefit rider
No health history questions are required to be answered.

27. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.
28. Rider availability varies by state. Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.

Lump Sum Cancer Benefit Builder rider
Only answer questions required for the Lump Sum Cancer policy.

Lump Sum Heart and Stroke Benefit Builder rider
Only answer question required for the Lump Sum Heart Attack & Stroke policy.

Commissions
The agent adding the rider will receive first-year commissions on the new premium associated with the new rider(s).

Other considerations

These riders can be added to Flexible Choice plans effective prior to 03/01/2020 as well as plans effective after 03/01/2020.

If a customer has a ROP (Return of Premium) Rider and adds additional riders after the initial policy sale, the ROP benefit and premium will automatically adjust in accordance with the additional rider(s).

Underwriting guidelines

Additional underwriting, including a prescription drug check and a live PV, is required on all benefit amounts over $50,000. Amounts under $50,000 will be at the discretion of the underwriter. A maximum of $75,000[29] may be issued to each of the following categories: Cancer, Heart Attack & Stroke, and Specified Disease (base and riders). *The underwriter will make the final determination in all cases.* See "Additional underwriting" on page 49.

Medical conditions including, but not limited to, those listed below are not insurable for any coverage.

- Acquired immune deficiency syndrome (AIDS)
- AIDS-related complex (ARC)
- Human immunodeficiency virus (HIV)

Cancer

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last five years.

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include non-melanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including, but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders including, but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Heart Attack & Stroke

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last five years.

Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots including, but not limited to:

- Aneurysm
- Angina pectoris
- Arteriosclerosis
- Atrial fibrillation/flutter
- Bradycardia
- Cardiomyopathy
- Carotid artery disease
- Cerebrovascular accident
- Congenital heart disease
- Congestive heart failure
- Cor pulmonale
- Dextrocardia

29. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.

- Endocarditis
- Myocarditis
- Pericarditis
- Peripheral atherosclerosis
- Premature ventricular contractions (PVC)
- Raynaud's phenomenon
- Rheumatic fever
- Tachycardia
- Temporal arteritis
- Tetralogy of fallot
- Thromboangitis obliterans disease
- Thromboembolic disease
- Pulmonary hypertension
- Diabetes associated with insulin use, excluding gestational diabetes, neuropathy or retinopathy
- High blood pressure for which three or more medications have been taken concurrently

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied.

Declinable Drug List

The Supplemental Solutions DDL (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions.

We will require a signed and dated letter from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is not listed on this application. This letter must state the condition for which the medication is being taken and must state that the applicant does not have the declinable condition on this list. Failure to include this letter with the application may lead to the declination of the application.

Height and weight chart

A height and weight chart will be used for adults who apply for the Heart Attack & Stroke base policy/rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity rider, Benefit rider, Hospital Indemnity Benefit rider, and Intensive Care Unit Indemnity Benefit rider. This chart will also be used when the above riders are applied for under the Flexible Choice Cancer product. See "Flexible Choice" on page 65.

Flexible Choice Hospital Indemnity

Benefits that help protect against the high costs of hospital expenses

952832e II/23

Introduction to Hospital Indemnity

Our Hospital Indemnity insurance coverage is designed to pay the policyholder specific benefit amounts for a range of hospital-related services and costs. The Senior Choice product is designed for customers age 50 and older and includes benefits for ambulance transportation, emergency room (ER) visits, hospital admission, hospital confinement, observation room use and skilled nursing facilities.

Features

- Renewability: Guaranteed renewable for life[30]
- Available riders, for an additional premium: Accident Fixed Indemnity Benefit rider, Lump Sum Cancer and Recurrence rider, Lump Sum Heart Attack & Stroke and Restoration rider, and Specified Disease rider[31]

See the customer product brochure for a chart of benefits that are included with each plan option.

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Preexisting condition periods may vary by state. Refer to the exclusions and limitations in the brochure.

Senior Choice Plan options

This product issues to ages 50–85 and offers three plans with an increasing amount of benefits for your customers to choose from: Senior Choice Plan One (SC1), Senior Choice Plan Two (SC2) and Senior Choice Plan Three (SC3). Once a plan is selected, your customers can choose from various benefit amount options that determine how much the plan will reimburse the policyholder if a covered service or event occurs.

Benefit[31]	SC1	SC2	SC3	Notes
Hospital confinement (per day)	X	X	X	Daily benefit between \$100 and \$450, available in \$25 increments; six- and 10-day benefit period available
Observation room		X	X	\$100 per day Limited to two visits per year
Skilled nursing facility (per day)		X	X	\$100 for days 21–100
Hospital admission			X	Option 1: \$250, Option 2: \$500, Option 3: \$750
Ambulance (air)			X	Lump sum benefit \$150 Limited to two visits per year combined with ground
Ambulance (ground)			X	Lump sum benefit \$150 Limited to two visits per year combined with air
Emergency room			X	Lump sum benefit \$50; limited to two visits per year

X means that the plan includes the benefit.

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means you and your child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

30. Subject to the Company's right to increase premiums on a class basis.
31. Rider availability varies by state. Check your state's Outline of Coverage or our Product Availability Chart for rider availability.
32. Benefits may vary by state.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (Effective date of the policy cannot be more than 90 days from the sign date of the application.)
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (if applicable)

The use of a Customer Booklet is required in all states. Please visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

Rates

Premiums are based on issue age and banded.

- Single age rated.
- Rates are unisex and uni-tobacco.
- Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill. See “Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart and Hospital Indemnity premium modes” on page 67.
- There is no policy fee or enrollment fee.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are guaranteed for the initial 12 months.

Optional benefits[33]

Accident Fixed Indemnity Benefit rider

Pays an indemnity benefit per unit upon accidental death or dismemberment of a covered insured. Dismemberment benefit pays according to the schedule provided in the Outline of Coverage. The available plans are Prime, Advantage or Supreme. The rider provides additional benefits for:

- Burns
- Concussion
- Dislocation of separated joints
- Emergency dental work
- Eye injury
- Fractured/Broken bone
- Laceration
- Paralysis
- Surgical procedures
- Accident emergency treatment
- Ambulance
- Appliance

33. Rider availability varies by state. Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.

- At-home recovery
- Attending physician
- Blood
- Plasma and platelets
- Diagnostic imaging

Lump Sum Cancer and Recurrence rider

The Lump Sum Cancer rider provides 100% of the selected benefit amount payable to the insured customer upon the diagnosis of invasive cancer or carcinoma in situ. If the insured is diagnosed within the first 30 days immediately following the effective date of the rider, the benefit amount payable will be reduced to 10% of the selected benefit amount and coverage for that insured person will be terminated. Available benefit amounts are between $5,000 and $50,000. Benefit choice must be the same for all insured persons.

The Cancer Recurrence benefit is subject to the Benefit Payment Conditions. The Cancer Recurrence Benefit is payable each time an insured person receives a diagnosis for the recurrence of cancer. However, for the Cancer Recurrence Benefit to be payable:

- The cancer diagnosis benefit amount to which this rider is attached shall have been previously paid for the insured person.
- The insured person shall not have received any advice or treatment for at least 24 consecutive months prior to the date of diagnosis for the recurrence of cancer.

The amount payable for the recurrence of cancer is equal to the percentage times the Cancer Recurrence benefit amount shown on the policy schedule page or policy endorsement. See "Heart Attack & Stroke Restoration rider and Lump Sum Cancer and Recurrence rider" on page 67.

Lump Sum Heart Attack & Stroke and Restoration rider

Our Lump Sum Heart Attack & Stroke and Restoration rider provides a scheduled benefit payable on the diagnosis or procedure under the policy for any of the qualifying events. Available benefit amounts are between $5,000 and $50,000. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured person or their designee. If the insured person receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions.

We will pay the Heart Attack & Stroke Diagnosis Benefit if an insured person receives a diagnosis of any of the qualifying events, subject to the definitions, terms, limitations and exclusions set forth in this rider, and the following conditions.

- The diagnosis must be made within the United States.
- The date of diagnosis is after the waiting period has expired.
- The date of diagnosis occurs while the insured person is covered by this rider.
- Payment shall be precluded by any general or specific limitation, exclusion or reduction set forth in or attached to this rider, including, without limitation, the exclusion for any preexisting condition or any failure by the insured person to meet any condition in this rider or policy. See "Lump Sum Heart Attack & Stroke qualifying events benefit amount" on page 66.

When 100% of the Heart Attack & Stroke Diagnosis benefit amount under this rider has been paid for an insured person, we will pay the Heart Attack & Stroke Restoration benefit when an insured person receives a diagnosis of a heart attack, stroke or heart transplant. However, for the Heart Attack & Stroke Restoration benefit to be payable, the Heart Attack & Stroke Restoration benefit diagnosis must be separated by at least 24 consecutive months from an insured person's last date of diagnosis for a heart attack, stroke or heart transplant under this rider.

The amount payable for the diagnosis of a heart attack, stroke or heart transplant is equal to the percentage times the Heart Attack & Stroke Restoration benefit amount shown on the policy schedule page or policy endorsement. See "Heart Attack & Stroke Restoration rider and Lump Sum Cancer and Recurrence rider" on page 67.

Specified Disease benefit rider

Available benefit amounts are between $5,000 and $50,000. We will pay the Specified Disease benefit amount shown in the policy schedule page if an insured person receives a diagnosis or

procedure from a physician for one of the specified diseases shown in the list below and subject to the following conditions.

- The diagnosis must be made within the United States.
- The date of diagnosis or procedure occurs while the insured person is covered by this rider.

Specified diseases:

- Amyotrophic lateral sclerosis (ALS)
- Coma
- End-stage renal failure
- Major organ transplant
- Multiple sclerosis (MS)
- Paralysis
- Severe burns

Underwriting guidelines

Questions 1–6: "Yes" answer to any question = no coverage issued.

Additional underwriting, including a prescription drug check and a live PV, is required on all benefit amounts over $50,000. Amounts under $50,000 will be at the discretion of the underwriter. A maximum of $100,000 in benefits may be issued to each of the following categories: Cancer, Heart Attack & Stroke, and Specified Disease (base and riders). *The underwriter will make the final determination in all cases.* See "Additional underwriting" on page 49.

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied.

Lump Sum Cancer and Recurrence rider

Question 7: "Yes" answer = no rider issued

Lump Sum Heart Attack & Stroke and Restoration rider

Question 9: "Yes" answer = no rider issued

Specified Disease benefit rider

Question 10–12: "Yes" answer to any question = no rider issued

Height and weight chart

A height and weight chart will be used for adults who apply for the Lump Sum Heart Attack & Stroke and Restoration rider. See "Flexible Choice" on page 65.

Cancer Treatment

Benefits that help cover the cost of care and treatment of cancer

952832e 11/23

Introduction to Cancer Treatment

Our Cancer Treatment Insurance policy pays your customer the benefit amount for the care and treatment of cancer from the coverage level they select. The cancer must be diagnosed after the waiting period has expired. Please refer to the Cancer Treatment Benefit Chart in the brochure for specific benefits, amounts and limits.

Basic features

- Issue ages: 18–99
- Renewability: Guaranteed renewable for life[34]
- Available riders, for an additional premium: Lump Sum Cancer rider, Lump Sum Heart Attack & Stroke rider, Hospital and Intensive Care Indemnity rider, Hospital Indemnity rider, Intensive Care Unit Indemnity rider, and Return of Premium rider[35]

Preexisting conditions

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition. Preexisting condition periods may vary by state. Refer to the Exclusions and Limitations in the brochure.

Coverage types

- The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.
- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (Effective date of the policy cannot be more than 90 days from the sign date of the application.)
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (if applicable)

The use of a Customer Booklet is required in all states. Visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

34. Subject to the Company's right to increase premiums on a class basis.
35. Rider availability varies by state. Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.

Rates

- Premiums are based on issue age and banded for ages 18–24 and then in five-year age bands from 25 to 99.
- Rates are unisex and uni-tobacco.
- Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill. See "Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart Attack, and Hospital Indemnity premium modes" on page 67.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee.

Optional benefits[36]

Lump Sum Cancer rider

The Lump Sum Cancer rider provides 100% of the selected benefit amount payable to the insured customer upon the diagnosis of invasive cancer or carcinoma in situ. If the insured is diagnosed within the first 30 days immediately following the effective date of the rider, the benefit amount payable will be reduced to 10% of the selected benefit amount and coverage for that insured person will be terminated. Available benefit amounts are between $5,000 and $100,000. Benefit choice must be the same for all insured persons.

Lump Sum Heart Attack & Stroke rider

Our Lump Sum Heart Attack & Stroke rider provides a scheduled benefit payable on the diagnosis or procedure under the policy for any of the qualifying events. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions. See "Lump Sum Heart Attack & Stroke qualifying events benefit amount" on page 66.

Hospital and Intensive Care Unit Indemnity Benefit rider

Cannot be sold with the Hospital Indemnity rider or the Intensive Care Unit Indemnity rider.

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness or complications of pregnancy. The confinement must be for at least 24 hours, and benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Hospital Indemnity Benefit rider

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a hospital as an inpatient due to injury, sickness or complications of pregnancy, including confinement to the intensive care unit or coronary care unit. The confinement must be for at least 24 hours, and benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Intensive Care Unit Indemnity Benefit rider

This rider provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the intensive care unit as an inpatient due to injury, sickness or complications of pregnancy. The confinement must be for at least 24

36. Rider availability varies by state.

hours, and benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Return of Premium Upon Death rider

Pays 100% of total premiums paid for the policy, and any riders less claims paid upon the death of primary insured.

Underwriting guidelines

Additional underwriting, including a prescription drug check and verification via PV, is required on all benefit amounts over $50,000. Amounts under $50,000 will be at the discretion of the underwriter. A maximum of $100,000 may be issued to each of the following categories: Cancer, Heart Attack & Stroke, and Specified Disease (base and riders). *The underwriter will make the final determination in all cases.* See "Additional underwriting" on page 49.

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy and riders.

- Acquired immune deficiency syndrome (AIDS)
- AIDS-related complex (ARC)
- Human immunodeficiency virus (HIV)
- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include non-melanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including, but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders, including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Any diagnostic tests related to cancer that have not been completed, test results not yet received or abnormal test results where cancer has not been ruled out within the last five years are not insurable for any coverage under the base policy/rider.

Treatment or diagnosis of non-melanoma skin cancer within the last five years will exclude any individual named from all benefits provided by the policy for the treatment of non-melanoma skin cancer.

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied.

Lump Sum Cancer rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider.

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include non-melanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including, but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders, including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Any diagnostic tests related to cancer that have not been completed, test results not yet received or abnormal test results where cancer has not been ruled out within the last five years are not insurable for any coverage under the base policy/rider.

Lump Sum Heart Attack & Stroke rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

- Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots, including but not limited to:
  - Aneurysm
  - Angina pectoris
  - Arteriosclerosis
  - Atrial fibrillation/flutter
  - Bradycardia
  - Cardiomyopathy
  - Carotid artery disease
  - Cerebrovascular accident
  - Congenital heart disease
  - Congestive heart failure
  - Cor pulmonale
  - Dextrocardia
  - Endocarditis
  - Myocarditis
  - Pericarditis
  - Peripheral atherosclerosis
  - Premature ventricular contractions (PVC)
  - Raynaud's phenomenon
  - Rheumatic fever
  - Tachycardia
  - Temporal arteritis
  - Tetralogy of fallot
  - Thromboangitis obliterans disease
  - Thromboembolic disease
  - Pulmonary hypertension
- Diabetes associated with insulin use, excluding gestational diabetes, neuropathy or retinopathy
- High blood pressure for which three or more medications have been taken concurrently
- Any diagnostic tests related to any disease of the heart or circulatory system that have not been completed or for which test results not yet been received within the last 10 years are not insurable for any coverage under the base policy/rider

Declinable Drug List

The Supplemental Solutions Declinable Drug List (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions.

We will require a signed and dated letter from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is not listed on this application. This letter must state the condition for which the medication is being taken and must state that the applicant does not have the declinable condition on this list. Failure to include this letter with the application may lead to the declination of the application.

Height and weight chart

A height and weight chart will be used for adults who apply for the Heart Attack & Stroke rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider, and Intensive Care Unit Indemnity Benefit rider. See chart on page 65.

All appeals require a signed and dated letter on letterhead from the treating/prescribing physician ruling out the declinable condition. For declines based on the medication taken, the letter must rule out the declinable condition and state the reason the medication was prescribed. Appeals should be faxed to **855.239.8763**, Attn: Underwriting. Please include assigned application number on the fax cover page. *The underwriter will make the final determination in all cases.*

Choice Accident

Benefits that help protect against accidental injury expenses

Introduction to Choice Accident

Choice Accident Insurance helps pay for deductibles, copays and out-of-pocket expenses if the policyholder or a family member is injured in a covered accident.[37]

Basic features

- Issue ages are 18-74.
- Coverage is available to the policyholder and their family members.
- Premiums are composite rated and are not determined by age or occupation.
- Benefits are paid directly to the policyholder or a person of their choice and can be used however they like.
- Worldwide coverage is available for accidental injuries.
- Policy isn't affected by any other insurance the policyholder may have.
- Policies are guaranteed renewable for life; only the policyholder can cancel.[38]
- There is no medical underwriting, so the policyholder does not need to provide medical history to qualify for coverage.
- There are no network requirements. Policyholders can use the doctors and facilities of their choice.
- Three policy options are available – Core, Preferred and Premier – offering varied benefits for Accidental Death and Accidental Dismemberment and Covered Injuries suffered in a covered accident.
- Applicant must have a Social Security number or an Individual Taxpayer Identification Number and reside within the United States.

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (Effective date of the policy cannot be more than 60 days from the sign date of the application.)
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)

37. Availability and benefits may vary by state and all benefits payable are subject to the terms and conditions of the policy.
38. Subject to the Company's right to increase premiums on a class basis.

- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (If applicable)*

The use of a Customer Booklet is required in all states. Visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

Rates

Premiums are composite rated and available for Primary, Primary and Spouse, One-Parent Family, and Two-Parent Family. There is one age band, for ages 18–74. Please refer to the Choice Accident Insurance Monthly Premiums Sheet (LOYAL-17-0003) on **CignaforBrokers** for details.

- Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill. See “Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart, and Hospital Indemnity premium modes” on page 67.
- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee.

Optional benefits[39]

Choice Accident coverage can be customized with optional riders, which are available for an additional premium.

Accident Disability rider

- Issue ages 18–64
- Guaranteed Renewable to age 74
- Composite Rated, with no excluded occupations/industries
- Minimum salary requirement of $15,000; no medical questions required
- Available to primary insured or primary insured/spouse

Policyholders receive $500 per month for up to six months with no preexisting condition clause and one premium rate for all working applicants. Available after a 14-day elimination period.

Parent Coverage rider

Add the policyholder’s and/or the spouse’s parents on the same application with coverage equal to the base level.

- Issue ages 18–74
- GI with no medical/health questions
- Guaranteed Renewable for Life
- Parents, in-laws, and stepparents all eligible as long as they live within the United States
- Accident Disability Insurance and Health Screening riders are not available on the Parent Coverage rider.[39]

Health Screening Benefit rider

This rider provides up to $50 per year to help pay for up to 26 health screenings, including:

- Blood test for triglycerides
- Bone marrow aspiration or biopsy
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)

39. Rider availability varies by state.

- Carotid doppler
- Chest X-ray
- Colonoscopy
- Echocardiogram
- Electrocardiogram
- Fasting blood glucose test
- Fasting plasma glucose (FPG)
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Hemoglobin A1c (HbA1C)
- Mammography
- Pap smear, including ThinPrep pap test
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine HDL/LDL
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- Two-hour, post-load plasma glucose
- Virtual colonoscopy

Accident Treatment

Benefits that help cover the cost of care and treatment of an accident

Introduction to Accident Treatment

The Accident Treatment Insurance policy pays your customer a fixed amount for the expenses they incur from an accident. The policy provides a predetermined benefit amount based on a benefit schedule that can be found in the brochure. Covered benefits can be categorized into the following, Accidental Injuries; Hospital and Services, and Accidental Death & Dismemberment.

Basic features

- Issue ages: 18–74
- Available benefit amounts: Basic, Plus, Enhanced; scheduled amounts vary by tier, but the list of covered benefits is consistent across all levels; tier selection is the same for all insured persons.
- Renewability: Guaranteed renewable to age 80[40]
- Available riders, for an additional premium: Lump Sum Cancer rider, Lump Sum Heart Attack & Stroke rider, Hospital and Intensive Care Indemnity rider, Hospital Indemnity rider, Intensive Care Unit Indemnity rider, and Return of Premium rider[41]

Preexisting conditions for riders

No benefits will be paid during the first 12 months for any loss caused by a preexisting condition under any applicable rider coverage. Preexisting condition periods may vary by state. Refer to the Exclusions and Limitations in the brochure.

Coverage types

The type of coverage issued is shown on the policy schedule page of the policy specimen or applicable policy endorsement. Definitions may vary by state.

- Primary Insured coverage means only customer, as shown on the policy schedule page or policy endorsement, is covered.
- Primary Insured and Spouse coverage means customer and spouse, as shown on the policy schedule page or policy endorsement, are covered.
- One-Parent Family coverage means customer and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.
- Two-Parent Family coverage means customer, their spouse and their child(ren), as shown on the policy schedule page or policy endorsement, are covered.

The sales process

Required forms

The Application Booklet includes point-of-sale forms that are required to be returned to the home office, including the:

- Application (Effective date of the policy cannot be more than 60 days from the sign date of the application.)
- Pre–Authorized Agreement for EFT (bank draft)
- HIPAA Notice
- Replacement Notice (if applicable)

The Customer Booklet must be given to the applicant at the time of sale. It includes the:

- Outline of Coverage
- Important Notice To Persons On Medicare (if applicable)
- Replacement Notice (if applicable)
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (If applicable)

The use of a Customer Booklet is required in all states. Visit **CignaforBrokers** for the proper Customer Booklet form for the appropriate state. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is required only if Medicare eligible.

40. Subject to the Company's right to increase premiums on a class basis.
41. Rider availability varies by state. Refer to the brochure and/or the Outline of Coverage for complete benefit amounts, limitations and exclusions.

NOTE: **Only one Cigna Healthcare Accident policy is allowed at a time.** If the applicant currently has an Accident Treatment policy and has applied for a Choice Accident policy (or vice versa, as available in the applicant's state), you must complete an internal replacement form to change to the new policy. If this form is not completed, the application will be declined.

Rates

Premiums are based on occupation class and issue age. Please refer to our Accident Treatment Occupation Guide (LOYAL-5-0016) for occupation classification. Premiums are banded for ages 18–24 and then in five-year age bands from 25 to 70+.

Four modes of premium payment are available: annual, semiannual, quarterly and monthly. Monthly is available only via bank draft or list bill. Quarterly, semiannual and annual are available via bank draft and direct bill. See "Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart, and Hospital Indemnity premium modes" on page 67.

- Additional premium modes may be available per product. Consult the product application and rate sheets for availability and modal factors.
- Rates are unisex and uni-tobacco.
- Rates are guaranteed for the initial 12 months.
- There is no policy fee or enrollment fee.

Optional benefits[42]

Some riders are underwritten and have qualifying health questions listed on the application.

Lump Sum Cancer rider

The Lump Sum Cancer rider provides 100% of the selected benefit amount payable to the insured customer upon diagnosis of invasive cancer or carcinoma in situ. If the insured is diagnosed within the first 30 days immediately following the effective date of the rider, the benefit amount payable will be reduced to 10% of the selected benefit amount and coverage for that insured person will be terminated. Available benefit amounts are between $5,000 and $100,000. Benefit choice must be the same for all insured persons.

Lump Sum Heart Attack & Stroke rider

Our Lump Sum Heart Attack & Stroke rider provides a scheduled benefit payable on the diagnosis or procedure under the policy for any of the qualifying events. The amount payable for each qualifying event is the percentage multiplied by the selected benefit amount. The amount payable for subsequent qualifying events is the lesser of the percentage payable or 100% minus the percentage of the benefit amount received for all previous qualifying events. Benefits are paid directly to the insured or their designee. If the insured receives partial payment for a procedure, the remaining percentage, up to a total of 100%, can be paid for other conditions. See "Heart Attack & Stroke Restoration rider and Lump Sum Cancer and Recurrence rider" on page 68.

Hospital and Intensive Care Unit Indemnity Benefit rider

Cannot be sold with the Hospital Indemnity rider or the Intensive Care Unit Indemnity rider.

This rider provides the customer with a selected hospital indemnity benefit amount for each day that they are confined to a hospital as an inpatient due to injury, sickness, complications or pregnancy. It will pay twice the selected hospital indemnity benefit amount for each day that an insured person is confined to the intensive care unit as an inpatient due to injury, sickness, complications or pregnancy. The confinement must be for at least 24 hours, and benefits will not be payable for more than 30 days

42. Rider availability varies by state.

for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Hospital Indemnity Benefit rider

This rider provides a selected hospital indemnity benefit amount for each day that a customer is confined to a hospital as an inpatient due to injury, sickness, complications or pregnancy, including confinement to the intensive care unit or coronary care unit. The confinement must be for at least 24 hours, and benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65, coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Intensive Care Unit Indemnity Benefit Rider

Provides a selected Intensive Care Unit Indemnity Benefit amount for each day that the customer is confined to the intensive care unit as an inpatient due to injury, sickness or complications of pregnancy. The confinement must be for at least 24 hours, and benefits will not be payable for more than 30 days for any one period of confinement. *Upon attainment of age 65 coverage for each insured person will be reduced by 50%, as shown on the policy schedule page.*

Return of Premium Upon Death rider

Pays 100% of total premiums paid for the policy and any riders less claims paid upon the death of the primary insured.

Underwriting guidelines

The base policy is guaranteed issue. Please refer to our Accident Treatment Occupation Guide (LOYAL-5-0016) for occupation classification.

Riders

Underwriting for all riders will be administered on an issue or reject basis only. No benefit or condition exclusions will be applied.

Medical conditions including, but not limited to, those listed below are not insurable for any coverage.

- Acquired immune deficiency syndrome (AIDS)
- AIDS-related complex (ARC)
- Human immunodeficiency virus (HIV)

Additional underwriting, including a prescription drug check and a verification via in person eSignature or PV, is required on all benefit amounts over $50,000. Amounts under $50,000 will be at the discretion of the underwriter.
A maximum of $100,000 may be issued to each of the following categories: Cancer, Heart Attack & Stroke, and Specified Disease (base and riders). *The underwriter will make the final determination in all cases.* See "Additional underwriting" on page 49.

Lump Sum Cancer rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

- Internal cancer
- Melanoma
- Malignant tumors
- Carcinoma in situ, although it does not include non-melanoma skin cancers, premalignant lesions, or benign tumors or polyps

Blood cancer including, but not limited to:

- Leukemia
- Lymphoma
- Non–Hodgkin's lymphoma
- Myelodysplastic syndrome
- Myeloma

Myeloproliferative disorders, including but not limited to:

- Polycythemia vera
- Chronic idiopathic myelofibrosis
- Essential thrombocythemia

Any diagnostic tests related to cancer that have not been completed, test results not yet received or abnormal test results where cancer has not been ruled out within the last five years are not insurable for any coverage under the base policy/rider.

Lump Sum Heart Attack & Stroke rider

Medical conditions including, but not limited to, those listed below are not insurable for any coverage under the base policy/rider if the customer has been diagnosed or received medical advice or treatment within the last 10 years.

- Disease or disorder of the heart or circulatory system, heart conditions, heart valve disorders, or blood clots, including but not limited to:
  - Aneurysm
  - Angina pectoris
  - Arteriosclerosis
  - Atrial fibrillation/flutter
  - Bradycardia
  - Cardiomyopathy
  - Carotid artery disease
  - Cerebrovascular accident
  - Congenital heart disease
  - Congestive heart failure
  - Cor pulmonale
  - Dextrocardia
  - Endocarditis
  - Myocarditis
  - Pericarditis
  - Peripheral atherosclerosis
  - Premature ventricular contractions (PVC)
  - Raynaud's phenomenon
  - Rheumatic fever
  - Tachycardia
  - Temporal arteritis
  - Tetralogy of fallot
  - Thromboangitis obliterans disease
  - Thromboembolic disease
  - Pulmonary hypertension
- Diabetes associated with insulin use, excluding gestational diabetes, neuropathy or retinopathy
- High blood pressure for which three or more medications have been taken concurrently

Any diagnostic tests related to any disease of the heart or circulatory system that have not been completed or for which test results not yet been received within the last 10 years are not insurable for any coverage under the base policy/rider.

DDL

The Supplemental Solutions DDL (CSB-9-0017-LSCH) helps agents identify possible uninsurable conditions. *We will require a signed and dated letter from the prescribing physician if the applicant is currently taking or has recently taken a medication in this list for a use that is not listed on this application. This letter must state the condition for which the medication is being taken and must state that the applicant does not have the declinable condition on this list. Failure to include this letter with the application may lead to the declination of the application.*

Height and weight chart

A height and weight chart will be used for adults who apply for the Heart Attack & Stroke rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider, and Intensive Care Unit Indemnity Benefit rider. See Chart on page 65.

All appeals require a signed and dated letter on letterhead from the treating/prescribing physician ruling out the declinable condition. For declines based on the medication taken, the letter must rule out the declinable condition and state the reason the medication was prescribed. Appeals should be faxed to **855.239.8763**, Attn: Underwriting. Please include assigned application number on the fax cover page. *The underwriter will make the final determination in all cases.*

General information

General information

New business guidelines

- A maximum of $75,000[43] may be issued for each of the following categories: Cancer, Heart Attack & Stroke, or Specified Disease (base and riders).
- You must be licensed with a resident or nonresident license in the state where the applicant resides. You must use the application based on the applicant's resident state. Applications received based on the agent's resident state will be returned. The mailing address state on the application must match the residence state. All policies must be mailed and delivered in the issuance state.
- If you are writing business in Texas, Oklahoma, Montana or Pennsylvania, you must be appointed by the company prior to soliciting your first application. Please contact Agent Contracting at **866.459.4272** or **CSBLicensing@CignaHealthcare.com** to verify your appointment status.
- You should make sure you complete all sections of the application for the requested coverage.
- All applications must be signed by the policy owner. Each page of the application must be signed when a power of attorney (POA) is used. Proof of POA is required. If any other applicants have assigned a POA to another individual and the POA is currently relied upon for handling the financial affairs of the applicant, then such applicant is not eligible for coverage.
- When submitting business using a POA, the following is required on the application:
  - POA's signature on the application signature lines (POA signature can be obtained via Express App's eSignature function [see "eSignature" on page 51] or via PV, as necessary [see "Phone Verification" on page 52].)
  - Sale applications
  - Exception: HOST and CONSERV agents complete PVs on a recorded line and
    - Do not require a PV
    - POA documents
    - POA's address (can be a non-residential address, such as a P.O. Box)
    - POA's phone number
- Your signature and assigned agent number must be included in the space provided on the application for the agent's information.
- If it is necessary to correct a mistake on the paper application, both you and the applicant must date and initial the strikeover in the presence of the applicant. Do not use correction fluid on the application.
- Applications must be received within 30 calendar days of date signed if you are appointed with the company in the state of issue. If you are not yet appointed with the company in that state, you must submit the application immediately.
- The effective date of the policy cannot be more than 90 days from the sign date of the application and cannot be day 29, 30 or 31 of the month. If the application is dated one of these dates, the effective date will be the first of the following month.
- Coverage does not begin until the effective date of the policy. Only losses incurred on or after the effective date of the policy will be considered under the terms and conditions of the policy.
- If two applications for the same product are submitted at the same time on the same person, the one with the earliest application date will be processed and the other will be withdrawn. Initial full modal premium must be submitted with all applications (except for faxed and Express App applications where the bank draft authorization can be completed for premium).
- Payer/payee guidelines: Due to the Patriot Act's broad anti-terrorism measures and the Federal Anti-Kickback Statute's prohibition on improper payments involving services reimbursable by a federal health care program, CSB's policy is to prohibit money laundering and other improper payments through detection, deterrence and prevention. Suspicious activity can include listing a payer, beneficiary or payee who is apparently an unrelated third party or who otherwise has no apparent relationship to the applicant or customer. CSB does not accept currency (cash), foreign currency, cashier's checks, money orders or traveler's checks as premium payments. A check drawn on the payer's own account, such as a personal check, is not considered cash. Each policy is an individual contract, and third-party/company

43. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.

checks/payments and/or representative payees are not acceptable for payment of any premium, unless from an immediate family member or when the payer is a Group/Association/Company and our Group/Association Direct/List Bill form has been submitted and approved for the billing process. See "Group/association setup form" on page 60.

- Acceptable third-party payor means one or more of the following:
  - A Group, Association, or Company that is providing retiree benefits via a health reimbursement account or that meets the requirements to be list billed;
  - A family member
  - A financial POA
  - An Indian tribe, a tribal organization or an urban Indian organization
  - A state or federal government program
  - An independent private not-for-profit entity, if all the following criteria are met.
    - » Assistance is provided on the basis of the insured's financial need.
    - » The entity is not a health care provider or supplier.
    - » The entity does not have any direct or indirect financial interests.
- All products require that the applicant must have a Social Security number and be a U.S. citizen or have held a permanent resident status for at least two years.

New business submission

All products in this guide may be submitted:

- Online via Express App, our web-based application tool
- By fax via our FaxApp Program See "FaxApp program" on page 52.
- By standard mail

Additional underwriting

Product and Underwriting alignment for Cancer, Heart Attack/Stroke and Specified Disease

Additional underwriting (including a prescription drug check) verification via PV is required on all benefit amounts over $50,000 and at the discretion of the underwriter on amounts of $50,000 and under.

A maximum of $100,000 in benefits per category – of Cancer, Heart Attack & Stroke, or Specified Disease – will be issued across all of our policies and companies.

Cancer Recurrence and Heart Attack/Stroke Restoration riders should not be added as part of the benefit amount because they only pay once the base pays.

Maximum issue amount per person, per category		Underwriting
Cancer	$100,000 combination of base and riders	PV for each person above $50,000, combination of base and riders
Heart Attack/ Stroke		
Other Specified Disease/CI		

Examples

Here are examples of how multiple Flexible Choice policy purchases affect policyholder benefits.

Scenario 1

Joe bought a Critical Choice Cancer policy in 2010 with a benefit amount of $25,000. Joe later buys a Flexible Choice Cancer base plan for $10,000. *Joe is under the $50,000 benefit amount and does not require additional verification via PV.*

Scenario 2
Sarah bought a Critical Choice Cancer policy in 2010 with a benefit amount of $25,000. Sarah later buys a buys a Flexible Choice Heart Attack base plan for $10,000 and a Cancer Rider for the same amount. *The $10,000 Cancer Rider contributes to the $100,000 maximum, but the overall benefit total for cancer coverage is $35,000, so Sarah is below the threshold and does not require additional verification via PV.*

Scenario 3
Mark bought a Critical Choice Cancer policy in 2010 with a benefit amount of $25,000. Jane, Mark's wife, wants to purchase a $50,000 Flexible Choice Cancer plan for both of them. *Jane would not need additional verification via PV because she is within the $50,000 threshold. However, Mark would go through verification via PV because his $50,000 would be added to the $25,000 he has in force.*

Scenario 4
Anna purchased a Critical Choice Cancer policy in 2010 with a benefit amount of $25,000. Anna now wants to purchase a Flexible Choice Cancer plan for $80,000. *We would require PV via for Anna because her total amount requested is above $50,000, but we would also reach out to Anna and advise that she is only eligible for $75,000[44] in coverage from Flexible Choice Cancer because no one can have more than $100,000 in coverage.*

Scenario 5
Pete bought a Critical Choice Cancer policy in 2010 with a benefit amount of $25,000. Pete wants to purchase a Flexible Choice Heart Attack plan for $80,000. *We would require verification via PV because his total amount requested is above $50,000. He can keep his cancer plan as well because each person can have up to $100,000 per category of coverage.*

Express App

Express App is a 100% online application process that makes submitting new business fast and easy. Go to CignaforBrokers.com and select the Express App tab to get started. Make sure to use Internet Explorer 11 or Google Chrome when accessing Express App. Older versions of Internet Explorer are no longer compatible.

Get quotes

- You will need your customer's age or date of birth, tobacco status, gender, and zip code to receive a Quick Quote. Annual, semiannual, quarterly and monthly premiums for all available plans in your state will display within seconds. Use the Family Quote to quote couples or families.
- Search our DDL by typing in the letters or words of a drug or drug-related condition.

Send proposals

- Click on the Send Forms button to securely email a proposal to your customer. To send proposals and email confirmations, your customer must first consent to receive documents electronically.
- Click the Send Forms button to open the consent window and follow the instructions.
- If mailing a proposal, please include the following:
  - Cover letter to customer from agent
  - Proposal (not available for those under 65, in some states and for some CSB Supplemental products)
  - State-approved brochure
  - Application
  - Outline of Coverage
  - CMS Guide
  - Agent business card

44. Available benefit is $5,000-$100,000 in some states. Check the Product Availability chart for the current list.

Personalized Enrollment Link

Your customers can finish an application for a quote that you created. Start an application and use the "Send Forms" button in Express App to send your customer a proposal with a link they can use to enroll themselves in Flexible Choice Dental, Vision & Hearing, and Medicare Supplement products in select states.[45]

Self-Enroll Link

Express App also includes a "Create a Self-Enroll Link" button for our Medicare Supplement and Supplemental Health products, including Flexible Choice Dental, Vision & Hearing, Accident Treatment, and Life Insurance products in select states.[45] You can send this link to your customers so they can enroll themselves in the selected product.

Learn how

Review the training on the CignaforBrokers portal for instructions on how to send personalized and self-enroll links.

Apply

- Once you have selected the desired products, tabs will appear that contain the application portion. Fill out information in all areas and tabs. We will gather electronic signatures during the application process through the eSignature function (see the following eSignature section).
- Express App will automatically check for missing information and prompt you to correct the errors.
- If you enter an email address to send the customer copies of the application and other required forms, the consent window will open when you submit the application and you will be prompted to complete the information and obtain the customer's acknowledgment.

Submit

- After you have input all of the customer's information, take time to go over it once more with them. After you have verified that all of the information is correct, go to the Review & Accept page and complete the required information, then click Accept.
- Once submitted, you and the applicant will receive a copy of the application and Outline of Coverage. If Medicare eligible, the applicant will also receive *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* via email. Select states must consent to receive as noted above.

eSignature

eSignature is the quickest way to complete an Express App application; it consists of two options: in person (all products) and remote email secure PIN (underwritten Medicare Supplement only).

For all products, in person eSignature is available if the customer is present with you, the agent, when completing an application in Express App.

For underwritten Medicare Supplement policies, you may email your customer a link to obtain a secure six-digit PIN using the Send Forms feature in Express App.

Your customer will then:

- follow the link in the email to a website that will provide the PIN, and
- share the PIN with you.

You will then:

- select the appropriate eSignature option on the Final Steps page in Express App, and
- enter the PIN in the space provided to sign.

45. DVH: AK, AL, AR, AZ, CA, CO, CT, FL, GA, HI, IA, IL, IN, KS, LA, MD, ME, MI, MN, MO, MS, MT, NE, NH, NV, OH, OK, PA, SC, TN, TX, UT, WI, WV and WY. Med Supp: Not available for LOYAL AK and DC.

FaxApp program

Submit applications via fax with our FaxApp program. Just fill out the FaxApp Cover Sheet and fax it, along with the application and all supporting documents, to **877.704.8186**.

A case number will be assigned and the application will be processed. Your commission will be generated the day after issue. See "FaxApp cover sheet" on page 63.

PV

A Phone Verification (PV) is a phone interview that applicants must complete for CSB to process faxed, some paper applications and for certain other transactions if an Express App is unsigned via the eSignature function. The PV acts as an electronic signature and verifies medical questions with the applicant. Completing the PV at the point of sale not only processes applications faster but it also helps you get paid faster. Refer to the chart for PV availability. A PV associate is available to take live PV calls Monday through Friday from 8:00 am to 5 pm (CT) at **866.825.4822**.

Tips for completing the PV

- Make sure you have completely filled out the application prior to calling our PV line. This includes going over the entire application if conducting the sale over the phone or using Express App.

Product		Express App	Phone/fax (no wet signature)	Paper/fax (with wet signature)
Medicare Supplement	OE/GI	Not needed	Live PV	Not needed[47]
	Underwritten	Not needed	Live PV	Not needed
Cancer, Heart Attack & Stroke, Accident		Not needed[46]	Live PV	Not needed[46]
Individual Whole Life		Live PV	Live PV	Live PV

- You (the agent) may initiate the PV call; however, the applicant must personally answer all questions. If the PV call is not initiated at the time of sale, it is your responsibility to make arrangements for the applicant to call as soon as possible.
- If the applicant completes the PV on their own, make sure they have:
  - The plan type or plan letter and the proposed rate
  - A list of their prescription medications with conditions
  - Their Medicare or Member Beneficiary number with Part A and Part B effective dates (the latter if applying for a Medicare Supplement plan)
- The PV will confirm that the applicant received the following.
  - Copy of the Application, if applying for Medicare Supplement
  - Copy of the Outline of Coverage
  - *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*
  - Any state-required forms

The PV cannot be conducted if you (the agent) does not have all of the previous information. Additionally, please inform the applicant that the PV interview can take 15–20 minutes, depending upon the applicant's medical history, and will include repeat questions from the application. Usual and customary underwriting procedures will remain in place.

46. Flexible Choice/Lump Sum over $50,000 requires a live PV.
47. Only applicable for Medicare Supplement customers.

Case number

Prior to completing the PV, you (the agent) will receive a PV case number that must be included on the app before submitting.

Multiple applicants

When an agent calls in requesting the PV, if both spouses are applying and available, the phone interviewer will conduct one interview, asking the questions one time and having both applicants respond to each question. This procedure could reduce the PV time for both applicants by about 20 minutes. No questions are asked regarding over-the-counter drugs. Outbound calls can only be conducted as one interview if there is a notification of both spouses applying on the application(s).

Steps to submitting a phone sale

Call your customer

Fill out the application in Express App while talking to your customer. If you're using a paper application, you don't need a wet signature. Just write "phone sale" followed by the customer's name in the signature block. The customer will provide a signature confirmation during the PV.

Conduct a PV

When applicable, simply conference in your customer and call the PV line at **866.825.4822**. See "Phone Verification (PV)" on page 52.

Submit the application

Submit the application via Express App, fax or mail. If the application is clean and submitted via Express App or fax, it can be issued in as little as three days. If the sale requires a PV, remember to enter the PV case number on the application.

New business processing

Delivery receipts, in states where required

For policies that are hand delivered by the agent to the customer:

- The agent should explain all the provisions and benefits to the customer, and once completed, the delivery receipt should be signed and dated by the customer and the agent.
- Return to the administrative office only if required by your state. The agent should keep a copy for his or her records.
- The agent should deliver policies within seven days of receipt.

Failure to submit the delivery receipt back to the administrative office will not result in the cancellation of the policy. In some states, this receipt is intended to protect the agent with proof of delivery. In other states, the receipt is required. All policies in states that require a delivery receipt are mailed with a certificate of mailing from the post office.

Declined applications

If a customer's circumstances fall outside of our limits of insurability, he or she will be notified of the decline in the form of a letter. This letter will identify the specific reasons for the decline. This letter is mailed to the applicant and agent.

Appealing a declined application

We will *require a signed and dated letter* from the treating physician for any appeal, based upon a declinable medication or in-house claims history, as stated above. The agent should contact the underwriter to determine what will be required with all *other* declines.

Appeals should be faxed to **855.239.8763**, Attn: Underwriting. Please include the assigned application number on the fax cover page.

The underwriter will make the final determination in all cases.

Recent surgical procedures

We will *require a signed and dated letter* from the treating physician if the applicant has had a surgical procedure within the past 90 days (or 30 days for cataract surgery). *This letter* must *state that the applicant has* completed *the requisite follow-up visits and therapy, and has been released from the doctor's care. Failure to include this letter* with *the application may lead to the declination of the application. The underwriter will make the final determination in all cases.*

Incomplete applications

If there is insufficient information on the application, we will contact the agent during the application process to obtain information. If the information is not received within 30 calendar days, the application is terminated as incomplete and a letter is sent to the applicant.

Applications with premium shortages

Applications submitted with premium shortages will be processed with the following guidelines:

- Up to $10.00

Policy will be issued with shortage amount taken from agent's commissions (in this case, the agent is expected to collect shortage amount from customer) or via bank draft.

- $10.01 or more

Policy will be issued with a coupon, which is a requirement of additional premium due. Notification of this action will be mailed with the policy to the agent. If the additional premium is not received within 45 days, the policy will be terminated and the initial premium refunded to applicant.

Customer service

Online portal

Customers have a paper-free place to keep track of claims, review account information and view coverage details: **myCigna.com**.

- View coverage details.
- Establish or update automatic premium payments.
- Print temporary ID cards.
- Update mailing addresses.
- View and sign up for paperless EOBs.
- Review claim payments.

Beneficiary add/change

To add a beneficiary designation or to designate a new beneficiary, a Beneficiary Designation Form (CSB-11-0010BDF) must be completed and signed. The full name of the beneficiary, date of birth, Social Security number, address and relationship to the insured must be stated on the form. The form must be signed by the primary insured and dated.

Name change

To change the name of the insured, a Relationship Change and Designation Form (CSB-11-0010RCDF) must be completed and signed. The full name of the insured must be shown on the form. The form must be signed by the primary insured and dated. The insured will need to send a copy of updated identification, such as driver's license, Social Security card or marriage certificate.

Electronic funds transfer (EFT)/ bank draft authorization change

To change the premium billing from direct billing to a bank draft, a Pre-Authorization for Electronic Funds Transfer form (CSB-9-0035- EFT) must be completed. The bank account number and routing number for the bank must be stated. The bank account holder must sign the form exactly as the signature appears on bank records. The bank account holder must sign the form authorizing us to draft from the account. If the withdrawal is from a savings account, utilize the savings account information provided by the bank/ financial institution. Also, a blank personal check with the word "void" across the face of the check must accompany the completed and signed authorization.

Addition/deletion of dependents

To add or remove a dependent, a new application is required, signed by the policy owner. Mark "Contract Change" from the options at the top of the application. If adding a dependent, the full name, date of birth, sex and relationship to the primary insured must be indicated and the medical questionnaire on the application must be completed. Upon receipt of the completed form, the underwriting department will review and make all final decisions on the dependent's eligibility for coverage. The dependent will be added effective the next premium due date following the approval date. The increased premium will be billed or drafted at that time.

To remove a dependent, the name of the dependent and the reason for removal must be indicated on the application. Completion of medical questions is not required as it is not applicable. Upon receipt of the completed form, the dependent will be removed from coverage and the premium will be adjusted accordingly.

Eligible child dependent

An eligible *child* dependent means your natural child, your stepchild, your legally adopted child, a child placed with you for adoption, a foster child or a court-appointed guardianship/order/administrative order for a child, including grandchild, who is:

- Insurable and named on the application
- Unmarried
- Chiefly dependent on you or your spouse for support
- Under age 26 (Ages may vary by state.)

This also includes dependent children, regardless of age, who:

- Are mentally or physically handicapped
- Became or become handicapped prior to the limiting age and cannot support themselves because of their handicap

When a spouse or dependent child is no longer eligible for coverage, a new application must be submitted for underwriting. For all other products, dependents who are no longer eligible for coverage, due to age, etc., must complete a new application within 31 days of attaining of age 26. The Conversion Policy will be issued without proof of good health subject to any conditions outlined in the contract.

Increase/decrease in coverage

For an increase in coverage, a new application is required and should be submitted as New Business, as we are unable to increase coverage on an existing policy. Upon receipt of the application, the underwriting department will review and make all final decisions for any benefit increase. A separate policy will be issued for the additional coverage.

For a decrease in coverage, a Contract Service form (CSB-11-0010PSF) is to be submitted and the Special Request field completed indicating the coverage change. The coverage will be decreased and the premium adjusted accordingly.

Reinstatements

When a policy lapses, a new application, signed by the primary insured, is required for reinstatement of the coverage, mark "Reinstatement" from the options at the top of the application, complete the medical questions and return to the underwriting department at the address indicated below. The application must be received within 30 days of the signed date on the form. If the policy is approved for reinstatement, it will be reinstated with the same policy number.

A letter will be sent from customer service stating that the reinstatement has been approved and indicating the amount of premium due. Do not submit monies with the completed application. If the reinstatement is declined, a letter will be sent from underwriting to the customer with the reason(s) why the policy was declined.

Contact customer service at **866.459.4272**, or submit request for reinstatement and completed applications to:
Cigna Healthcare Supplemental Benefits
PO Box 5725 | Scranton, PA 18505-5725.
Fax: **888.670.0146** | **CSBSupport@Cigna.com**

Bank draft/auto-pay

Checking account setup

If the monthly (bank draft/auto-pay) method of payment is chosen from a checking account, complete the entire EFT agreement in the application packet and obtain the signature of the person who will assume financial responsibility for the policy. If faxing, attach a voided check of the account that will be drafted with the FaxApp cover sheet. Include the bank routing number and account number, as we cannot process the application without this information. See "FaxApp cover sheet" on page 63.

Savings account setup

If the monthly bank draft or auto-pay method of payment from a savings account is chosen, we must have proof of the account number written in the bank draft authorization section. If mailing or faxing the application, you must send a deposit slip for verification of the account. The applicant should obtain, from their bank, the appropriate routing number to draft from a savings account, as the routing number listed on the savings account deposit slip may not be correct. Mark through the routing number on the deposit slip and write in the correct routing number for withdrawals, as provided by the bank. We cannot process the application without this information.

If submitting multiple applications please make sure that *each* application has the bank information completed and signed by the person responsible for payment. *Each* application must also have a voided check for checking accounts or a deposit slip for a savings account attached.

Bank drafts

All policies will draft the initial premium upon the date of the policy activation/issue, regardless of the requested date of coverage. Subsequent drafts will occur on the applicant's chosen draft date. The applicant may select any day, excluding the 29th, 30th or 31st of the month. If no draft date is indicated on the application, the drafts will occur on the same day of the month corresponding to the effective date of the policy. For example, if the policy is effective April 15, the policy will draft subsequent premiums on the 15th of each month.

Direct bill

Direct billing is available for all premium modes, except monthly.

Commissions

Advances

If approved by your upline and the Company, advance commissions may be available. Advance commissions on newly issued business will be credited to your account on a daily basis. Advances are paid via direct deposit into the account we have on file for that agent. We will only advance commissions when the initial premium is paid via monthly bank draft/EFT or the customer's personal preprinted check. We will not advance commissions for business written on family members.

Earned first-year and renewal commissions are credited to your account on a biweekly basis. You can find the schedule for biweekly commission statements on **CignaforBrokers** (Compensation > Commissions).

Advances are paid in increments of 6, 9 or 12 months. For Medicare Supplement, advances are paid in increments of 6, 9, 12 and 15 months. Interest is charged on all secured advance balances from inception until they are paid off (not applicable for CHLIC or CNHIC Medicare Supplement advance commissions – no interest is charged.) An advance balance for an in-force policy (secured advance balance) is paid off by commission earned on that specific policy. Once the advance balance is paid off, future earned commissions are payable to the agent. If the advance balance becomes unsecured (the policy lapses, etc.), then the advance balance record is changed to an unsecured advance balance. These unsecured balances are paid off by holding 100% of all commissions payable, new advances, and earned first or renewal commissions, until recovered. CSB reports only earned commissions as taxable amounts on agent 1099s.

The maximum advance on Whole Life is $1,500 per policy. Remember, if death occurs in year one, we will do a full charge-back on the policy. This will result in a commission reversal. Please refer to your commission schedule for information about commission reversals and charge-backs.

As a reminder, advance commissions are only paid on bank draft business and only at the original activation of the policy.

If you have any questions about your commissions, you can contact Commissions at **877.454.0923**.

Agent services

CignaforBrokers

CignaforBrokers(CignaforBrokers.com) gives you the tools to effectively manage your business. All business and customer service forms are available on **CignaforBrokers**. You can also download applications, track your business, view commission statements and much more.

To create an account:

1. Go to CignaforBrokers.com/web/create-account/access-code.
2. Enter your last name.
3. Enter access code.
   - If you are an agent, your access code is C + Writing Agent Number + last six digits of Social Security number+A
   - If you are not an agent, your access will be provided to you via email.
4. Enter a username. Username must be 4 to 30 characters long, contain at least 1 letter and have no more than 5 digits in a row.
5. Enter a password. The password must be at least 6 characters long (no spaces), and contain at least 1 number and 1 letter. (Accepted symbols: _ ! , & @)
6. Enter your password again.
7. Enter your email address and phone number.
8. Select two security question and answers, and click Next.
9. Read and agree to the Terms & Conditions, check the check box, and select the Create Account button.

If you are registering a corporate tax ID number or agency, please enter the last name and Social Security number of the principal and add "SYS" to the front of the writing number. If you need assistance registering for or logging in to the website, please contact our Agent Resource Line at **877.454.0923**.

Agent notices

Many email communications and agent notices are sent on a weekly basis to give you the most up-to-date information. A current and correct email address is necessary to receive agent notices, as well as obtain email confirmations when you submit business to us. To update your email address and other contact information, email the Licensing Department at CSBLicensing@Cigna.com.

Advertising review and approval

All advertising materials, including print, email, websites, presentations, etc., regardless of whether its purpose is for consumers or agents, must be approved by our Compliance and Marketing Departments prior to use. Anything intended to generate public interest in an insurance product, a company or an agent is considered to be advertising. There are two ways to receive approval of your personal advertising using any of our company names, logos or products.

- If you have created an original advertisement, a logo licensing agreement must be executed and you must submit the advertisement for approval.
- Guidelines and materials for requesting the licensing agreement and submitting the ad for approval using the Advertising Material Review Request Form (CSB-9-0024) are available on CignaforBrokers under Business Building > Creating Ads.
- If you are interested in one of our preapproved advertising materials, you can refer to the CSB Prospecting Portfolio (CSB-9-0031) for a variety of advertisements for Medicare Supplement only. The CSB Prospecting Portfolio can also be found on CignaforBrokers under Business Building > Creating Ads.

Once you submit/select your advertisement, allow a minimum of five business days for the Compliance Department to review the advertisement.

- CSB will contact the agent with approval of the advertisement or notification of changes that must be made to comply with advertising policy and regulations. *Many advertising pieces will also require approval by the applicable state department of insurance.*

- For any previously disapproved advertising material to be considered further, it must be resubmitted to the Home Office with all of the necessary revisions.
- Once an advertising piece is approved, the Compliance Department will assign an advertisement form number, which must be included in the advertisement. *This approval is good for a period of six months.* Any subsequent use of the advertisement after this period must be resubmitted for approval.

For more information about our advertising policies, please call our Compliance Department at **877.454.0923 ext. 8074794**.

Group/association

All supplemental products are eligible under a Section 125 Cafeteria Plan; however, the Return of Premium rider and the Cash Value rider cannot be offered under a Section 125 Cafeteria Plan.

Setting up your group/association

Email the "Group/Association Setup" form to the Group/Association Case Coordinator at CSB_GroupSetup@CignaHealthcare.com.

On the initial setup, all applications must have the same effective date. If approved, you will be assigned a CSB Group Number and must then:

- Fill out the appropriate application for each member (Franchise Application required for Ohio), and
- Include the assigned CSB Group Number on every application and cover sheet and fax them to the Group/Association Case Coordinator. *If paying via list bill, you must also include the Payroll Deduction Form.*

You must wait until you get all of the applications before sending them to the New Business Department.

If customers are paying their premium via bank draft or direct bill, you are finished.

If paying via list bill, you must make a copy of all of the payroll deduction forms and give them to the Payroll Administrator.

Portability

The insured may keep the coverage on an individual basis in the event he or she leaves the employer or the membership of an association. No conversion is necessary.

Payroll deduction and association eligibility requirements

A minimum of five lives are required for the list bill payment method with full underwriting. Applications that do not meet the minimum requirement may be marketed for bank draft or direct bill premium payment options.

Employee and member eligibility requirements

Individuals who currently qualify for disability benefits, or have been diagnosed as HIV positive or with AIDS or ARC are not eligible.

Eligible associations

To be considered eligible for this program, an association must operate with a charter and/or bylaws and provide support programs or benefits of significance to members. In addition, the association cannot be formed solely to obtain insurance coverage. Professional, trade and employer associations are examples of associations that would qualify.

Associations must agree to cooperate with the agent and promote awareness/participation among its members.

Payroll deduction premium and billing information

Two options are offered for employers.

- List bill – This is an option when there are at least five issued policies.
- Bank draft – The Payroll Administrator may choose to remit the premiums for their employees by means of a common employer account utilizing bank draft, only when employee premiums are payroll deducted.

Association premium and billing information

Two options are offered for association business.

- Bank draft – Applicants may choose to pay their premiums through a personal bank account on an individual EFT basis.

- Direct bill – Applicants may choose to pay their premiums on an individual quarterly, semiannually or annually direct bill basis.

Approval process

Each employer/association must be approved prior to any business being written. Please complete the Group/Association Setup Form and email CSBPremiumReferrals@Cigna.com or fax to 888.670.0146. The Case Coordinator will provide the agent with the association number within two days.

This number must be included in the designated area of each application on all future business submitted.

Issue dates

For list bill business, listing an issue date on the application is mandatory and should be based on the employer having deducted at least one month's premium.

For example, if an employer started deducting September 1, the issue date would be October 1. For bank draft or direct bill, an issue date may be requested but is not mandatory.

Submission of new business

If requesting the list bill payment option, you should hold the applications until you have reached the minimum of five lives. Applications using bank draft or direct bill payment options can be submitted up to 60 days after the application sign date. Applications using the list bill payment option can be submitted up to 90 days after the sign date. With either payment option, the requested effective date on an application can be up to 90 days from the application sign date.

Premium with application

- Bank draft – May submit first month's premium with application, but it is not required.
- Direct bill – Pay the first premium with the application. (Required)
- List bill – May submit first premium payment, but it is not required.
- Regular mail – Must be accompanied by a check or completed bank draft form for the first modal premium.

  New Business/Imaging
  PO Box 5725
  Scranton, PA 18505-5725

  Overnight and Express Mail
  Cigna Healthcare Supplemental Benefits
  11501 Alterra Pkwy Suite 500
  Austin, TX 78758

GROUP/ASSOCIATION SETUP FORM

Please complete this form and email to: CSB_GroupSetup@CignaHealthcare.com Attn: Group/Association Case Coordinator Each Employer/Association must be approved before any business may be written or submitted.

- Employer must submit applications on at least five lives and must maintain a minimum of five lives to be eligible for group/association.
- Please type or carefully print all of the following information.

EMPLOYER/ASSOCIATION INFORMATION

Employer/Association name: Tax ID number:

Street address: Phone number:

City: State: Zip: Fax number: ( )

Nature of business: Email address:

PRODUCTS TO BE WRITTEN

☐ American Retirement Life Insurance Company *(Referred to as "Company")* ☐ Cigna Health and Life Insurance Company ☐ Cigna National Health Insurance Company ☐ Loyal American Life Insurance Company

Products to be written: ____

Are any existing products intended to be replaced? ☐ Yes ☐ No If "Yes," which ones:

BILLING CONTACT INFORMATION (list bill only)

Should the initial bill be verified with the Agent prior to contacting the employer to confirm enrollment is complete?
☐ Yes ☐ No

Billing contact person and title: Ext.:

Billing address *(if different from above):* City: State: Zip:

BILLING SET-UP INFORMATION

Billing method *Please select one:* ☐ Monthly bank draft ☐ List bill
Note: To calculate list bill premium, multiply the annual/monthly bank draft premium by the appropriate factor. (see Agent Guide)

Bank draft only: *Drafts will occur from:* ☐ Each individual member's account ☐ One employer account

List bill only: Premium billing order *(Please select one):* ☐ Alpha ☐ Social Security # ☐ Policy #
Billing frequency *(How often bill is sent):* ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual
☐ Other *Refer to the product application for available "other" billing frequencies.*

First payroll deduction date: ☐ None: Benefits are employer paid

Requested issue date: ***(The issue date is the day the first payment is due.)***

AGENT INFORMATION

Servicing Agent name: Service Agent Number:

Email address: Fax number:

Note: Policy issue dates should be based on at least five weekly or three biweekly deductions having been made. Please refer to the product application for available 'other' billing frequencies.

Billings are mailed 5 days prior to the premium due date.

GROUP/ASSOCIATION SETUP FORM

If you are requesting Group EFT, List Bill, or Payroll Deduction, this section must be completed

Employer agrees to PAYROLL DEDUCTION program: ☐ Yes ☐ No

Employer agrees to make payroll deduction of premiums, as authorized by employees, and forward the aggregate sum thereof to the Company upon the receipt of the list bill. The Employer bears no liability, responsibility or obligation for the employee's insurance or for the late payment or premium except as provided herein. Employer agrees that from the date of payroll deduction, the sums withheld are the property of the Company, and the Employer holds such amounts as an agent of the Company with the sole obligation of remittance.

If Employer mandates a minimum participation level before payroll deduction will be authorized, state participation level here:

____

The Company agrees to furnish a statement indicating the premium due by each participating employee. Employer agrees to make remittance within 10 days of its receipt of the monthly statement. Employer also agrees to promptly notify the Company of the name, address and phone number of any participating employee who leaves its employment, or withdraws a salary deduction authorization of from whom payment will not be made. If Employer terminates this agreement by 30 days' written notice to the Company, Employer will be fully discharged upon remittance of premiums theretofore deducted. In the event premiums are no longer to be withheld by payroll deduction, the premiums are to be paid directly by the Employee to the Company.

If an Employee's premium is altered from the date of application, the Company will communicate this with the agent at the time of policy issue. It is the agent's responsibility to communicate these changes in premium to the Employer and coordinate the update in premium deduction for the Employee.

AGENT AND EMPLOYER REPRESENTATIVE ACKNOWLEDGMENT:

No agent may accept risks, alter or amend policies or procedures, or waive any provisions of the Payroll Deduction Program or policy. To the best of my knowledge, the information on this form is correct.

I acknowledge the policies applied for are individual policies subject to each employee's voluntary election to apply, enroll, and continue to make payments to keep their individual policy active either through a payroll deduction of other available methods.

I acknowledge each applicant has been notified and understands the policy applied for is an individual policy and not group coverage by the Employer.

I acknowledge policy changes should be initiated by the member and require authorization forms to be completed.

I acknowledge each applicant will be notified either through the Employer or Agent on any changes to the policy effective date prior to issuance of a policy and it will be the individual employee's responsibility to make any changes to the policy after issuance.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company and Cigna National Health Insurance Company. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc.
© 2023 Cigna Healthcare

PAYROLL DEDUCTION FORM

Please complete this form and upload the Payroll Deduction form to ExpressApp during the application submission.

Employee Authorization for Deduction of Premiums from Salary: I hereby request that you deduct from my salary and forward to the Company the appropriate premium. Such deductions will cease upon (1) termination of my employment, (2) written notice by me requesting that deductions cease and stating when such cancellation is to be effective, (3) termination of this payroll deduction plan, or (4) written notice from the Company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization of my part, verbal or written, provided that the insurance company above certifies in writing that the changes in premium uniformly affect all members of the class to which I belong.

I authorize the Service Agent to receive or have access to the billing status of my policy.

I understand each policy applied for are individual policies and not group coverage by the Employer.

To add or change a service agent the customer must submit a written request PO Box 5700 Scranton, PA 18505

INFORMATION

Employee's name *(print)*:____

Date____________________ Employee SSN number:___________________________

Spouse's name *(if applicable)*:____

Approximate monthly premium:________ Employee: $_________ Spouse: $__________________ Total: $______________________

Requested effective date:____________________________________

Employee's signature: ____

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company and Cigna National Health Insurance Company. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc.
© 2023 Cigna Healthcare

NEW BUSINESS SUBMISSION FORM/FAXAPP

To: Cigna Supplemental Benefits (Fax #: 877.704.8186)

Agent Information (Required)

From:	
Phone #:	Fax #:
Writing #:	Email:
Date:	Number of pages: + cover

Applicant Information (Required)

Name:	SS#:
Name:	SS#:
Name:	SS#:
Name:	SS#:
Name:	SS#:

All applications submitted with a single cover sheet must be from the same writing agent.

Procedures

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a Combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. However, do not exceed 25 pages per transmission.

Simply complete the application, and fax the following to **877.704.8186**.

- FaxApp cover sheet
- Application in numeric page order
- Any state-specific or replacement forms, if applicable
- Copy of the initial premium check, if collected from the customer at the point of sale

Premium

- Agents are encouraged to utilize the Bank Draft Authorization form to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant, please indicate the case number on the check and mail the check, stapled to the top of the FaxApp cover sheet, to:

  Imaging – New Business
  PO Box 5725, Scranton, PA 18505-5725

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating that the contract will be cancelled in five days, unless we receive payment for the issued contract. If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the policy has been cancelled due to non-payment of premium.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company and Cigna National Health Insurance Company. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE are owned by Cigna Intellectual Property, Inc.
© 2023 Cigna Healthcare

Height and weight charts

Medicare Supplement

Applicants whose weight is outside the limits in the build chart do not qualify for coverage. Selected conditions include tobacco use, diabetes, or maintenance medications for heart and vascular conditions. Applicants with one of the selected conditions whose weight is greater than the maximum weight in the "Maximum weight with selected conditions" column do not qualify for coverage.

Applicants with one of the selected conditions whose weight is greater than the maximum weight in the "Maximum weight with selected conditions" column may qualify for the Standard II or Standard III class. Check your state's Outline of Coverage or our Product Availability chart for availability.

Height	Minimum weight for all classes	Maximum weight for Preferred Class	Maximum weight with selected conditions
4'0"	61	131	118
4'1"	64	137	123
4'2"	66	143	128
4'3"	69	148	133
4'4"	71	154	138
4"5"	74	160	144
4'6"	77	166	149
4'7"	80	172	155
4'8"	83	178	160
4'9"	86	185	166
4'10"	89	191	172
4'11"	92	198	178
5'0"	95	205	184
5'1"	98	212	191
5'2"	101	219	197
5'3"	105	226	203
5'4"	108	233	209
5'5"	111	240	216
5'6"	115	248	223
5'7"	118	255	229
5'8"	122	263	236
5'9"	125	271	244
5'10"	129	279	251
5'11"	133	287	258
6'0"	137	295	265
6'1"	140	303	272
6'2"	144	312	280
6'3"	148	320	288
6'4"	152	329	296
6'5"	156	337	303
6'6"	160	346	311
6'7"	164	355	319
6'8"	168	364	327
6'9"	173	373	335
6'10"	177	383	344
6'11"	181	392	352
7'0"	186	400	361

Flexible Choice

Use the following chart when any of the following are applied for: Heart Attack & Stroke base policy/rider, Heart Restoration rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider, and Intensive Care Unit Indemnity Benefit rider. This chart will also be used when the above riders are applied for under the Flexible Choice Cancer product.

Cancer Treatment

Use the following chart when any of the following riders are applied for: Heart Attack & Stroke rider, Hospital and Intensive Care Unit Indemnity Benefit rider, Hospital Indemnity Benefit rider, and Intensive Care Unit Indemnity Benefit rider.

Height and Weight (all genders)	
Height	Weight (not more than)
4′8″	190
4′9″	198
4′10″	205
4′11″	211
5′0″	219
5′1″	226
5′2″	233
5′3″	240
5′4″	247
5′5″	252
5′6″	258
5′7″	262
5′8″	269
5′9″	279
5′10″	289
5′11″	300
6′0″	311
6′1″	319
6′2″	326
6′3″	333
6′4″	338
6′5″	343
6′6″	351
6′7″	358

Tables and charts

Medicare Supplement premium modes

Mode	Bank draft	Direct bill	List bill
Monthly	0.0833[48]	N/A	0.09
Quarterly	0.265	0.265	0.265
Semiannually	0.520	0.520	0.520

Individual Whole Life premium modes

Mode	Bank draft	Direct bill
Monthly	0.0875	N/A
Quarterly	0.265	0.265
Semiannually	0.520	0.520

Cancer Treatment, Accident Treatment, Flexible Choice Cancer & Heart, and Hospital Indemnity premium modes

Mode	Bank draft	Direct bill	List bill
Monthly	0.085	N/A	0.85
Quarterly	0.265	0.265	0.265
Semiannually	0.520	0.520	0.520

Dental, Vision & Hearing and Choice Accident premium modes

Mode	Direct bill	List bill
Monthly	0.0833	0.0833
Quarterly	0.2500	0.2500
Semiannually	0.5000	0.5000

Lump Sum Heart Attack & Stroke qualifying events benefit amount

Qualifying events	Percentage of benefit amount payable	Max percentage of benefit amount payable
Heart attack	100%	100%
Heart transplant or combination, including heart	100%	
Stroke	100%	
Coronary artery bypass surgery[49]	25%	
Aortic surgery[49]	25%	
Heart valve replacement/repair surgery[49]	25%	
Angioplasty[49]	10%	
Stent[49]	10%	

48. For ID, MI, MN and OR, the rate is 0.085.
49. Payable only once in an insured person's lifetime.

Heart Attack & Stroke Restoration rider and Lump Sum Cancer and Recurrence rider

<table>
<tr><th>Time period without advice or treatment</th><th>Percentage of benefit amount payable</th><th>Max percentage of benefit amount payable</th></tr>
<tr><td>Less than 24 months</td><td>0%</td><td rowspan="4">100%</td></tr>
<tr><td>24 months through 5 years</td><td>25%</td></tr>
<tr><td>5 years through 10 years</td><td>75%</td></tr>
<tr><td>More than 10 years</td><td>100%</td></tr>
</table>

CSB Data Availability: Please review this document to learn which information CSB can readily provide agents, information that is available with a HIPAA release on file and information that is unavailable for release by law.

Appendices

Appendix A: Producer's guide to the anti-money laundering program for agents and producers of the life insurance companies comprising Cigna Healthcare Supplemental Benefits

As an insurance producer, your skills and services help your customers achieve financial success and security. Because you are on the front lines of a multibillion dollar industry, you are in a unique position not only to serve your customers but also to serve the country by helping prevent money laundering and the financing of terrorist activities.

To comply with the federal anti-money laundering regulations for insurance companies, CSB has adopted a detailed anti-money laundering program. You have an important role to play in that program. As a person who deals directly with customers, you will often be in a critical position to obtain information regarding the customer, the customer's source of funds for the products you sell and the customer's reasons for purchasing an insurance product. You should expect to collect and retain information needed to assess the risk associated with a particular piece of business – in particular, to identify customers in high-risk businesses, customers in high-risk geographic locations, or those using products or services that may be more susceptible to abuse in money laundering or other illegal activity.

Required training

Federal regulations (31 CFR 103.137) require CSB insurance companies to provide their agents and producers with ongoing anti-money laundering training. To avoid delays in new business processing, CSB requires that you successfully complete anti-money laundering training provided by LIMRA on an annual basis.

If you are appointed with another insurance company(s) that also utilizes LIMRA for its AML training, you need only take the training once. LIMRA will automatically share the results with all other insurance companies you are appointed with that use LIMRA for its training.

- Visit Aml.Limra.com and enter your username and password in lowercase letters in the spaces provided. The login function is case sensitive. Your username is your National Producer Number (NPN). If this is your first time accessing the course, your password is your last name.
- Change your password.
- Click on the Login button.
- Complete one of the appropriate anti-money laundering courses. CSB will automatically receive notification of your course completion.

If you have any AML training program questions, please contact CSB Agent Contracting at 877.454.0923.

Customer information gathering

To sell individual whole life insurance policies and other insurance products offered by a CSB insurance company that have a cash value or an investment feature, CSB's anti-money laundering program requires you to ensure that all information requested on the product application form and on any associated documents is accurate and complete. If a customer resists providing any requested information, appears to have provided false or misleading information, refuses to provide an acceptable form of identification, or has otherwise provided information that cannot be verified, before contracting you should promptly contact the CSB Compliance Department at CSBBusinessCompliance@Cigna.com and follow any instructions you are given. Records of this information must be retained as long as the policy or contract remains in force and for five years thereafter.

CSB insurance companies have developed a Notice and Customer Information Form (AR-NCIF or LY-NCIF) to help ensure that all required customer information is obtained. At this time, this form must be used in all individual whole life product sales and in connection with the sale of any other individual insurance product that has a cash value or investment feature. An exception may be available as determined by the CSB Compliance Department for a final expense product, but only if a personal history interview and prescription verification are utilized by the CSB insurance company during the underwriting process.

Suspicious activity reporting

You must immediately notify us if you detect any money laundering red flags so that CSB can determine whether a suspicious activity report (SAR) must be filed with the U.S. Department of the Treasury. Typically a SAR must be filed within 30 days of the initial detection of the suspicious activity.

Insurance industry red flags include, but are not limited to:

- The purchase of a product that appears to be inconsistent with a customer's needs
- The purchase or funding of a product that appears to exceed a customer's known income or liquid net worth
- Any attempted unusual method of payment, particularly by currency or cash equivalents such as money orders, traveler's checks or cashier's checks
- Payment of a large amount broken into small amounts
- Little or no concern expressed by a customer for the investment performance of an insurance product but much concern expressed about the early termination features of the product
- The reluctance of a customer to provide identifying information or the provision of information that seems fictitious
- A customer inquiring about how to borrow the maximum amount available soon after purchasing the product
- Listing a beneficiary or payee who is apparently an unrelated third party or who otherwise has no apparent relationship to the customer
- A customer who applies for a policy out of state when the same or a similar product is available in his or her home state
- The customer who uses an out-of-state mailing address
- Any other activity that you think is suspicious

If you identify any suspicious activity or money laundering red flags, you must promptly notify the CSB Compliance Department at CSBBusinessCompliance@Cigna.com. In that regard, you may be asked by the CSB AML Compliance Contact or by other CSB management personnel to investigate further or obtain additional information from the customer. If so requested, you must expeditiously obtain any requested information so CSB can determine in a timely manner if a SAR needs to be filed.

The CSB AML Compliance Officer/Contact has the sole responsibility for determining whether to file a SAR and for responding to any regulatory agency's, customer's, employee's, agent's or producer's inquiry regarding suspicious activity or SAR. The fact that a suspicious activity is under investigation or that a SAR has been filed or considered – including the contents of any SAR that has been filed – is strictly confidential. An agent or producer must not, under any circumstances, disclose that a suspicious activity is under investigation or that a SAR has been filed or is being considered – including the contents of a SAR – to the subject of the suspicious activity investigation or SAR or to any third party. Violations of confidentiality related to suspicious activity investigations or reporting may result in substantial civil and/or criminal penalties.

Methods of payment

You should advise the customer that only the following types of payment may be used to purchase an insurance product from a CSB insurance company.

- Properly completed pre-authorized checking account drafting form
- Personal check made payable to the appropriate insurer/subsidiary
- Properly completed payroll deduction authorization form
- Wire transfers and other forms of EFT
- Checks from another financial institution made payable to a CSB insurance company for the benefit of a new or existing customer

If a customer gives you an unacceptable form of payment, you should explain what forms of payment are acceptable, return the unacceptable payment immediately and notify the CSB AML Compliance Contact of the red flag. You should also notify the CSB AML Compliance Contact if you encounter difficulty dealing with a customer regarding CSB's standards for acceptable and unacceptable forms of payment. The CSB Compliance Contact can be reached at CSBBusinessCompliance@Cigna.com.

Both CSB insurance companies and their producers share the responsibility of compliance with CSB's AML Program and all applicable anti-money laundering laws. A failure to do so will constitute grounds for discipline up to and including termination of your contract for cause. In addition, violation of anti-money laundering laws may expose those responsible to substantial civil and criminal penalties under federal law.

Appendix B: Contact list

We value you as an agent with Cigna Healthcare Supplemental Benefits. Your business is very important to us, and we strive to make doing business with us as easy as possible. Your recruiter/upline should be your first point of contact. You can also contact the numbers and or email addresses listed below for ongoing matters.

Contact	Phone	Fax	Email
Agent resource line	877.454.0923		
Phone verification (PV) hotline	866.825.4822		CSBNewBusiness@Cigna.com
All claims	866.459.1755	512.531.1480	
New business	877.454.0923	888.695.2591	CSBNewBusiness@Cigna.com
Underwriting	877.454.0923		CSBNewBusiness@Cigna.com
Commissions	877.454.0923	512.590.6045	CSBCommissions@CignaHealthcare.com
Licensing and website registration	877.454.0923	888.832.4154	CSBLicensing@CignaHealthcare.com
Website login assistance	877.454.0923		CSBNewBusiness@Cigna.com
Product availability	877.454.0923		CSBAgentMarketing@Cigna.com
Customer service	877.454.0923	888.670.0146	CSBSupport@Cigna.com
FaxApp submission		877.704.8186	
Premium accounting		888.670.0146	CSBPremiumReferrals@Cigna.com
Supplies			Refer to CignaforBrokers to order.

Addresses

New Business/Imaging
PO Box 5725
Scranton, PA 18505-5725

Overnight and Express Mail
Cigna Healthcare Supplemental Benefits
11501 Alterra Pkwy Suite 500
Austin, TX 78758

Customer Services
PO Box 5700
Scranton, PA 18505-5700

Products insured by Cigna Health and Life Insurance Company, American Retirement Life Insurance Company, Cigna National Health Insurance Company, or Loyal American Life Insurance Company.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group. The Cigna names, logos, and marks, including THE CIGNA GROUP and CIGNA HEALTHCARE, are owned by Cigna Intellectual Property, Inc. Subsidiaries of The Cigna Group contract with Medicare to offer Part D Prescription Drug Plans (PDPs) in select states. Enrollment in a Cigna Healthcare product depends on contract renewal.

952832e 11/23 © 2023 Cigna Healthcare. Some content provided under license. For agent use only.