Cigna HealthCare of Illinois, Inc.

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

Cigna HealthCare of Illinois, Inc. ("Cigna")

Cigna US-IL Connect 6650-1

Health Maintenance Organization (HMO)

OUTLINE OF COVERAGE

READ YOUR EVIDENCE OF COVERAGE (EOC) CAREFULLY. This outline of coverage provides a very brief description of the important features of your EOC. This is not the insurance contract and only the actual EOC provisions will control. The EOC itself sets forth, in detail, the rights and obligations of both You and Cigna HealthCare of Illinois, Inc. It is, therefore, important that you **READ YOUR EOC CAREFULLY!**

A. Coverage is provided by Cigna HealthCare of Illinois, Inc. (referred to herein as "Cigna"), a health maintenance organization (HMO) which is organized under the laws of the State of IL.

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

Cigna HealthCare of Illinois, Inc.
Individual Services – Illinois
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C. An HMO Plan requires that the Member use providers in the Cigna network.

A **Participating Provider** is a Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities which are: (i) licensed in accordance with any applicable Federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna to provide services to Members.

A **Non-Participating Provider** (Out-of-Network Provider) is a Provider who does not have a Participating Provider agreement in effect with Cigna at the time services are rendered. Services from Non-Participating Providers are not covered, except for Emergency Medical Treatment. You will be responsible for the full cost of non-emergency services from a Non-Participating Provider.

D. Covered Services and Benefits

See page 4 for complete benefit schedule.

Deductibles

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

Family Deductible applies if You have a family plan and You and one or more of your Family Member(s) are insured under the EOC. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. The Individual Deductible paid by each Family Member counts towards satisfying the Family Deductible. Once the Family Deductible amount is satisfied, the remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits.

Out-of-Pocket Maximum(s)

Individual Out-of-Pocket Maximum means the annual limit on Out-of-Pocket expense for each Member covered under the EOC. Once the Individual In-Network Out- of -Pocket Maximum has been met for the Year, for Covered Services received from Participating Providers, You will no longer have to pay any Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty Charges do not apply to the Individual In-Network Out -of -Pocket Maximum and will always be paid by You. The Individual Out -of -Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers. It includes Deductible, Coinsurance and Copayments for medical services incurred from Participating Providers. It also includes Pediatric Dental and Vision expenses. The amount of the Individual Out-of-Pocket Maximum is shown in the Schedule of Benefits.

Family Out-of-Pocket Maximum applies if You cover other Family Member(s), and means the maximum amount of Deductible, Coinsurance and Copayments You and your Family Member(s) will be responsible to pay for Covered Services in a Year. Each Member can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket maximum. When the Family Out-of-Pocket is met, You and Your Dependent(s) will no longer be responsible to pay Coinsurance or Copayments for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits for the EOC.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Emergency Services delivered in the Emergency department of a Hospital is determined based on:

- Usual, reasonable and customary charges made by providers of such service or supply in the geographic area where it is received as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charge for a service, and that fairly and accurately reflects the market rate; or
- An agreed-upon rate between Cigna and the Provider.

The Maximum Reimbursable Charge for all other Covered Services is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or

- Usual, reasonable and customary charges made by providers of such service or supply in the geographic area where it is received as compiled in a nationally-recognized database that uses generally accepted industry standards and practices for determining the customary and reasonable billed charge for a service, and that fairly and accurately reflects the market rate; or
- The median amount negotiated with Participating Providers for the same services; or
- A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

E. BENEFIT SCHEDULE

The following is the Schedule of Benefits, including medical, prescription drugs and pediatric vision benefits. The Plan sets forth, in more detail, the rights and obligations of both You and Your Family Member(s) and the Plan. It is, therefore, important that all Members **READ THE ENTIRE PLAN CAREFULLY!**

Services for Out-of-Network providers are not covered except for initial care to treat and stabilize an Emergency Medical Condition. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT AVAILABLE EXCEPT AS DESCRIBED IN THE "EMERGENCY SERVICES" PROVISION OF THE "SERVICES AND BENEFITS" SECTION OR WITH THE PRIOR APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Members are entitled to receive the services and benefits set forth in this Schedule, subject to payment of Copayments, Percentage Copayment and any applicable Deductible as specified in the Schedule, and subject to the conditions, limitations and exclusions of this Plan.

Services that require Prior Authorization include, but are not limited to, inpatient Hospital services, inpatient services at any Other Participating Healthcare Facility, outpatient facility services, advanced radiological imaging, non-emergency ambulance, and Transplant Services. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Prior Authorization requirements for Prescription Drugs are detailed in the "Prescription Drugs" section of the Plan.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Medical Benefits	
Annual Deductible **Individual** **Family**	$6,650 $13,300 Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.
Out-of-Pocket Maximum **Individual** **Family**	$7,150 $14,300 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Coinsurance	You and Your Family Members pay 50% of Charges after the Annual Deductible
Prior Authorization Program **Prior Authorization – Inpatient Services**	Your Participating Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance.
Prior Authorization – Outpatient Services **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more information in Your Plan. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefits Details".	Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.
Preventive Care Services Please refer to "Preventive Care-Periodic Health Examinations" section of the Plan for additional details.	0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member who is under age 19. Please be aware that not all contracted vision care providers provide all vision care services as part of their practice. Please check with the provider to verify that he or she offers the services you wish to receive under his/her Cigna participating provider agreement.	
Comprehensive Eye Exam Limited to one exam per year	0% per exam Deductible waived
Pediatric Frames for Children Limited to one pair per year	0%per pair Deductible waived
Eyeglass Lenses for Children Limited to one pair per year Single Vision, Lined Bifocal, Lined Trifocal, Lenticular	0% per pair Deductible waived
Contact Lenses and Professional Services for Children (Limited to one pair per year)	
Elective	0% per pair Deductible waived
Therapeutic	0% per pair Deductible waived
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	
Physician Services	
Office Visit	
Primary Care Physician (PCP)	Visits 1-3 per Year: $45 Copayment, all visits after the first 3 per Year: 50%
Specialist Physician (including consultant and referral services)	50%
NOTE: if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory	

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Electronic visit with an Expanded Access Telehealth Physician **Note: if an Expanded Access Telehealth Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions.**	$40 Copayment
Physician Services, continued	
Surgery in Physician's office	50%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	50%
In-hospital visits	50%
Allergy testing and treatment/injections	50%
Second Surgical Opinion	0% Deductible waived
Hospital Services	
Inpatient Hospital Services	
Facility Charges	50%
Professional Charges	50%
Emergency Admissions	Benefits are shown in the Emergency Services Schedule
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services **Facility and interpretation charges**	
Physician's Office	50%
Free-standing/Independent lab or x-ray facility	50%
Outpatient hospital lab or x-ray	50%
MRIs, MRAs, CAT Scans, PET Scans	50%
Short-Term Rehabilitative Services Physical, Occupational and Speech Therapy	50%
Naprapathic Services Maximum of 15 visits per Member, per Calendar Year	50%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Member, within a six month period	50%
Chiropractic Services Maximum of 25 visits per Member, per Calendar Year	50%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	50%
Habilitative Services	50%
Family Planning	
Womens' Contraceptive Services and Sterilization	0% Deductible waived
Male Sterilization	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Maternity (Pregnancy and Delivery)/Complications of Pregnancy	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office visit benefit applies
Prenatal services, Postnatal and Delivery (billed as "global" fee)	50%
Hospital Delivery charges	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	50%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	50%
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	50%
Treatment of Autism Spectrum Disorder Please refer to "Autism Spectrum Disorder" section of the Plan for specific details and limitations.	Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Home Health Services	50%
External Prosthetic Appliances	50%
Durable Medical Equipment	50%
Hospice **Inpatient** **Outpatient**	Inpatient Hospital Services benefit applies 50%
Newborn/Infant Hearing Screening	0% Deductible waived
Hearing Aids (limited to hearing aids for children and bone anchored hearing aids) Maximum of 2 hearing aids for children every 3 years	50%
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness **Inpatient** (Includes Acute and Residential Treatment) **Outpatient** (Includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services	Inpatient Hospital Services benefit applies $45 Copayment 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Substance Use Disorder	
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	$45 Copayment
All other outpatient services	50%
Organ and Tissue Transplants- (see benefit detail in "Covered Benefits" section for covered procedures and other benefit limits which may apply.)	
Cigna LIFESOURCE Transplant Network® Facility **LIFESOURCE Transplant Network® Facility Travel Maximum**: $10,000 per Member, per transplant	0%
Other Cigna Network Facility	50%
Out-of-Network Facility	NOT APPLICABLE
Infertility **(see "Covered Benefits" section for specific information about what services are covered and benefit limits which may apply).**	50%
Bariatric Surgery	50%
Infusion and Injectable Specialty Prescription Medications and related services or supplies	50%

Emergency Services ***(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Cigna Contract Allowance	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge
Emergency Services		
• **Hospital Emergency Room**		
Emergency Medical Condition	50%	In-Network benefit level
Non-Emergency Medical Condition	50%	Not Covered
• **Urgent Care Services**		
Emergency Medical Condition	50%	In-Network benefit level
Non-Emergency Medical Condition	50%	Not Covered
• **Ambulance Services** Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	50%	In-Network benefit level
Non-Emergency Transport	Not Covered	Not Covered
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
• **Hospital Facility Charges** Emergency Services from a Non-Participating Provider are covered at the Participating Provider benefit level until the patient is transferrable to a Participating facility. Non-Participating facility benefits are not covered once the patient can be transferred,	50%	In-Network benefit level until transferable to an In-Network Hospital

Emergency Services ***(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Cigna Contract Allowance	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge
whether or not the transfer takes place. • **Professional Services** Emergency Services from a Non-Participating Provider are covered at the Participating Provider benefit level until the patient is transferrable to a Participating facility. Benefits for Non-Participating Provider Professional Services are not covered once the patient can be transferred, whether or not the transfer takes place.	50%	In-Network benefit level until transferable to an In-Network Hospital

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY Preferred Pharmacy and Network Pharmacy YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
In the event that You request a Brand Name drug that has a Generic equivalent, You will be financially responsible for the amount by which the cost of the Brand Name drug exceeds the cost of the Generic drug, plus the Generic Copayment or Coinsurance shown in the Benefit Schedule.		
Prescription Drug Deductible	Integrated medical and Prescription Drug Deductible	
	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Cigna Mail Order Pharmacy Drug Program** **YOU PAY PER PRESCRIPTION OR REFILL:**

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY Preferred Pharmacy and Network Pharmacy YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Tier 1: Preferred Generic	$30 Copayment per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply. You pay a Copayment for each 30 day supply.	$90 Copayment per Prescription or refill Up to a 90 day maximum supply
Tier 2: Non-Preferred Generic	$35 Copayment per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply. You pay a Copayment for each 30 day supply.	$105 Copayment per Prescription or refill Up to a 90 day maximum supply
Tier 3: Preferred Brand	35% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply.	35% per Prescription or refill Up to a 90 day maximum supply
Tier 4: Non-Preferred Brand	40% per Prescription or refill 30 day supply at any Participating Pharmacy or	40% per Prescription or refill Up to a 90 day maximum supply

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY Preferred Pharmacy and Network Pharmacy YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
	Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply.	
Tier 5: Specialty Generic and Brand Name	45% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply.	45% per Prescription or refill Up to a 90 day maximum supply
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's contraceptives) that are: ▪ Prescribed by a Physician ▪ Generic or Brand Name with no Generic alternative)	0% Deductible waived per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a designated subset of Pharmacies contracted to provide a 90 day supply.	0% Deductible waived per Prescription or refill Up to a 90 day maximum supply

F. ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

By enrolling, You are choosing to have services and benefits under the "Services and Benefits" Section provided by, or arranged for by, a Primary Care Physician. The Primary Care Physician maintains the physician-patient relationship with Members who select him or her as their Primary Care Physician. The Primary Care Physician is responsible to Cigna for providing and/or coordinating Medical Services and Hospital Services for overall health care needs of such Members.

Choosing a Primary Care Physician

When You enroll as a Member, You must choose a Primary Care Physician (PCP). Each covered Member of Your family also must choose a PCP. If You do not select a PCP, we will assign one for You. If Your PCP ceases to be a Participating Physician, You will be able to

choose a new PCP. You may voluntarily change Your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Calendar Year that You will be allowed to change Your PCP. If You select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following Your selection. If You select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if You notify us on June 10, the change will be effective on July 1. If You notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which You may receive services. Your choice of a specialist may be limited to specialists in Your PCP's medical group or network, including a Limited Network. Therefore, You may not have access to every specialist or Participating Provider in your Service Area. Before You select a PCP, you should check to see if that PCP is associated with the specialist or facility You prefer to use. If the Referral is not possible, You should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making Your selection.

If Your PCP Leaves the Network

If Your PCP or Network Specialist ceases to be a Participating Physician, We will notify You in writing of his or her impending termination at least 30 days in advance of the date the PCP leaves the network and provide assistance in selecting a new PCP or identifying a new Network Specialist to continue providing Covered Services. If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that Provider.

Referrals to Specialists

You must obtain a Referral from Your PCP before visiting any provider other than Your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that You may make to a provider within a specified period of time. If You receive treatment from a provider other than Your PCP without a Referral from Your PCP, the treatment is not covered.

Exceptions to the Referral process:

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Covered Services," without a Referral from Your PCP. If Your plan covers Expanded Access Telehealth Service, You do not need a PCP referral for electronic visits with an Expanded Access Telehealth Physician.

If You are a Member under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Network Vision Provider for Pediatric Vision Benefits without a Referral from Your PCP.

You do not need a Referral from Your PCP for Emergency Services as defined in the "Definitions." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral from Your PCP for Emergency Services, but You do need to call Your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, You should seek immediate medical attention and then as soon as possible thereafter You need to call Your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but You should, whenever possible, contact Your PCP for direction prior to receiving services.
You may also visit a qualified Participating Provider for covered Pediatric Vision Care Services and Pediatric Dental Care Services, as defined in “Covered Services”, without a referral from Your PCP.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than Your PCP when all of the following conditions apply:

1. You are a covered Member of the Cigna HMO Plan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with a network specialist determines that Your care requires another provider’s expertise;
4. Your PCP determines that Your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by Your PCP to a network specialist who will be responsible for providing and coordinating Your specialty care; and
6. The network specialist is authorized by Cigna to provide the services under the standing referral.

We may limit the number of visits and time period for which You may receive a standing referral. A standing referral may be effective for up to 12 months and may be renewed and re-renewed by Your PCP. If You receive a standing referral or any other referral from Your PCP, that referral remains in effect even if the PCP ceases to be a Participating Physician. If the treating specialist leaves Cigna’s network or You cease to be a covered Member, the standing referral expires.

Transition Care

If Your PCP or network specialist leaves Cigna's network of health care providers, for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by at State licensing board, and remains within the Service Area of the EOC, You can continue an ongoing course of treatment with that Physician during a transitional period:

1. Of 90 days from the date of the notice from Cigna that Your Physician’s termination as a Network Provider if You are in an ongoing course of treatment; or
2. If You have entered the third trimester of pregnancy at the time You receive notification of Your Physician’s termination as a Network Provider, You can receive transition care from that Physician through delivery and post-partum care related to the delivery.
3. In either instance above, Your Physician must agree to:

a) Continue to accept reimbursement from Cigna at the rates applicable prior to the start of the transitional period; and

b) Adhere to Cigna's quality; and

c) Otherwise adhere to Cigna's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorizations for treatment.

4. You must request transitional services in writing within 30 days from Your receipt of notification that Your PCP or specialist Physician has terminated as a Network Provider. Within 15 days of Your request, Cigna will notify You if Your request for transitional

services was denied because Your Physician did not agree to one or more of the conditions listed under #3 above. This notification will be in writing and will include the specific reasons for the denial.

If You are a new enrollee and Your Physician is not a member of Cigna's provider network, but is within the Service Area for this Plan, You can continue an ongoing course of treatment with that Physician during a transitional period:

1. Of 90 days from the Effective Date of coverage under this Plan if you are in an ongoing course of treatment; or
2. If You have entered the third trimester of pregnancy on or prior to the Effective Date of Your coverage under this Plan, You can receive transition care from that Physician through delivery and post-partum care related to the delivery.
3. In either instance above, Your Physician must agree:
   a. To accept reimbursement from Cigna at rates established by Us; these rates shall be the level of reimbursement applicable to similar Physicians within the Network for such services; and
   b. Adhere to Cigna's quality; and
   c. To otherwise adhere to Cigna's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining pre-authorization for treatment.
4. You must request transitional services in writing within 15 days from Your receipt of notification of the availability of transition care services. Within 15 days of Your request, Cigna will notify You if Your request for transitional services was denied because Your Physician did not agree to one or more of the conditions listed under #3 above. This notification will be in writing and will include the specific reasons for the denial.

Note: Transition care does not provide You with coverage for benefits or services not otherwise covered by this Plan.

Network Exception

If You receive covered services from a Non-Participating Provider for:

- treatment of an Emergency Medical condition; or
- which You have a referral from Your PCP to a Non-Participating Provider; or
- Medically Necessary care that is not available from a Participating Provider; or
- any reason We determine it is in Your best interests to receive care from a Non-Participating Provider, then:

Coverage received through the Non-Participating Provider is limited to:

- Covered Services to which You would have been entitled under the EOC, and
- You will be responsible for only the amount of Non-Participating Provider Covered Expenses that You would have incurred if You received the services in-Network. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider. We will provide You with an explanation of benefits and request that You notify Us if the Non-Participating Provider bills You for amounts beyond the amount paid by Us. We will then resolve any amounts the Non-Participating Provider bills You beyond the amount paid by Us, consistent with You being held harmless for any

amounts beyond what You would have paid for the same services from a Participating Provider.

For all situations listed above except for Emergency Medical Conditions, Prior Authorization must be obtained before receiving care from a Non-Participating Provider.

G. Emergency Services and Benefits

Cigna provides reimbursement for emergency care at the Participating Provider level for treatment of an Emergency Medical Condition.

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

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

Emergency Services means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but you do need to call your PCP or the CIGNA HealthCare 24-Hour Health Information Line SM as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP or the Cigna HealthCare 24-Hour Health Information Line SM will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency Services for Sexual Assault Victims Full coverage is provided for examination, testing and treatment of a victim of a sexual offense to the extent of coverage provided for any other emergency or accident care. Such coverage shall additionally be provided when establishing that sexual contact did or did not occur, testing for the presence of sexually transmitted disease or infection, or examining and treating any injuries and trauma associated with the sexual offense.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information Line SM or your

PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or by Cigna.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the Cigna HealthCare 24 Hour Health Information Line SM or your PCP for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP, a Participating Physician or upon Prior Authorization of the Cigna Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Plan, and you will be reimbursed for only the costs that you incur that you would not have incurred if you received the services in-network.

H. Member's Financial Responsibility

You are required to pay all Copayments and Member Coinsurance for services rendered. Copayments and Coinsurance are subject to change from time to time. You are liable for all Copayments and Coinsurance incurred by Yourself and any of Your Dependents. See Your Schedule of Benefits for further detail.

Cigna will not accept the payment of premiums by any person or entity other than You, Your Family Members or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. If Cigna receives any payment of premium in respect of this Plan from any source other than You, Your Family Members or an Acceptable Third Party Payor, such payment will be considered a basis for the cancellation of this Plan.

I. Exclusions, Limitations, and Reductions

Any services which are not described as covered in the Benefit Summary, Services and Benefits section, or in an attached rider, or are specifically excluded in the Services and Benefits section benefit language or an attached rider, are not covered under this Plan.

Benefit Exclusions

In addition, the following are specifically excluded Services:

1. Care for health conditions which has not been provided by, provided by referral from Your PCP or authorized by Your PCP or the Cigna Medical Director, except for immediate treatment of a Medical Emergency/Emergency Medical Condition.
2. Services received before the Effective Date of coverage.

3. Services received after coverage under this Plan ends.
4. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
   - Yourself or Your employer;
   - a person who lives in the Member's home, or that person's employer;
   - a person who is related to the Member by blood, marriage or adoption, or that person's employer.
5. Care for health conditions that are required by state or local law to be treated in a public facility.
6. Care required by state or federal law to be supplied by a public schools system or school district.
7. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
8. Treatment of an Illness or Injury which is due to war, declared or undeclared.
9. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
10. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
11. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational or unproven services do not include routine patient care costs related to qualified clinical trials as described in your Plan document.
12. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.

The following services are excluded from coverage regardless of clinical indications;

- Macromastia or Gynecomastia Surgeries;
- Surgical treatment of varicose veins;
- Abdominoplasty;
- Panniculectomy;
- Rhinoplasty;

- Blepharoplasty;
- Redundant skin surgery;
- Removal of skin tags;
- Acupressure;
- Craniosacral/cranial therapy;
- Dance therapy, movement therapy;
- Applied kinesiology;
- Rolfing;
- Prolotherapy; and
- Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

13. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition, except as provided under the Pediatric Dental Care benefit. However, Charges made for services or supplies provided for or in connection with a fractured jaw, or an accidental injury to sound natural teeth are covered, where the continuous course of treatment is started within six (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch, except for pediatric dental services.
14. Any medical and surgical services for the treatment or control of obesity that are not included under the “Covered Services” section of the EOC.
15. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
16. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Services and Benefits."
17. Reversal of male and female voluntary sterilization procedures.
18. Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex unless such services are deemed medically necessary or otherwise meet applicable coverage requirements.
19. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
20. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the EOC.
21. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety and services, training except otherwise specifically covered in this Plan.
22. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance which is provided after the resolution of the

acute medical problem and when significant therapeutic improvement is not expected, except as specifically stated in the EOC.

23. Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnotism; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under “Short Term Rehabilitative Therapy” and “Habilitative Therapy” are not subject to this exclusion

24. Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.

25. Educational services except for Diabetes Self-Management Training; counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.

26. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", Diabetic Services”, or “Breast Reconstruction and Breast Prostheses” sections of the “Services and Benefits” section. Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, Durable Medical Equipment items that are not covered, include but are not limited to those listed below:

    - Hygienic or self-help items or equipment;
    - Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
    - Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
    - Institutional equipment, such as air fluidized beds and diathermy machines;
    - Elastic stockings and wigs;
    - Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
    - Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
    - Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
    - Hearing aid batteries (except those for cochlear implants) and chargers.

27. Private hospital rooms and/or private duty nursing except as provided in the “Home Health Services” or “Hospice Services” section of “Services and Benefits.”, or when deemed medically appropriate by Us. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.

28. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of Illness or Injury.
29. Orthopedic shoes (except when joined to braces), shoe inserts, foot orthodic devices except as required by law for diabetic patients.
30. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in “Services and Benefits” section of the EOC.
31. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
32. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery and pediatric vision).
33. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
34. Treatment by acupuncture.
35. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Services and Benefits.”
36. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
37. Membership costs or fees associated with health clubs, weight loss programs.
38. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
39. Dental implants for any condition.
40. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Cigna Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
41. Blood administration for the purpose of general improvement in physical condition.
42. Cost of biologicals that are immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
43. Cosmetics, dietary supplements and health and beauty aids.
44. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
45. All vitamins and medications and contraceptives available without a prescription (“over-the-counter”) except for those covered under mandate of the 2010 Patient Protection and Affordable Care Act (PPACA).

46. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
47. The following mental health and substance use disorder services are specifically excluded from coverage under this Plan:
    - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Plan;
    - Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
    - Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
    - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
    - Counseling for activities of an educational nature.
    - Counseling for borderline intellectual functioning.
    - Counseling for occupational problems.
    - Counseling related to consciousness raising.
    - Vocational or religious counseling.
    - I.Q. testing.
    - Residental treatment (unless associated with Mental Health or chemical or alcohol dependency as described in the Mental Health Residential Treatment Services or the Subtance Use Disorder Residential Treatment provisions);
    - Complementary and alternative medicine services, including but not limited to: animal therapy, including but not limited to equine therapy or canine therapy; art therapy; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
    - marriage counseling;
    - Custodial Care, including but not limited to geriatric day care.
    - Psychological testing on children requested by or for a school system
    - Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
    - Biofeedback is not covered for reasons other than pain management.
    - Orthognathic treatment and surgery, dental and orthodontic services, and dental and orthodontic appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)

In addition to the provisions of this "Exclusions and Limitations" section, You will be responsible for payments on a fee-for-service basis for Services under the conditions described in the "Reimbursement" provision of “Other Sources of Payment for Services."

Benefit Limitations

Circumstance Beyond the Cigna HMO Plan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan, we will make a good faith effort to provide or arrange for the provision of the service or supplies, taking into account the impact of the event.

The Plan does not provide Prescription Drug Benefits for:

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

Except as otherwise set forth in this "Prescription Drugs" section, the following Prescription Drugs and Relates Services are specifically excluded from coverage::

1. Any drugs not approved by the Food and Drug Administration.
2. Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary.
3. Any drugs available over the counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over the counter drug other than insulin, aspirin, or smoking cessation aids, except those required to be covered under the Patient Protection and Affordable Care Act.
4. Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
5. Any injectable infertility drugs and any injectable drugs are covered under the medical benefits of this Plan and require Prior Authorization. The following are examples of Physician supervised injectable drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
6. Any drugs that are experimental or investigational, within the meaning set forth in the EOC.
7. Any Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized as safe and effective for the treatment of the particular indication in one of the standard reference compendia (drug information for the healthcare provider, The United States Pharmacopoeia Drug Information, or The American Hospital Formulary Service Drug Information) or in medical literature, meaning scientific studies published in a peer-reviewed national professional medical journal.
8. Any Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug, and the medically necessary services associated with the administration of the drug, are recognized as safe and effective for the treatment of the Member's specific cancer in at least one standard medical reference compendia or medical literature. Standard medical reference compendia include: The American hospital formulary service drug information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium; Other Authoritative Compendia as identified by the Secretary of the United States Department of Health and Human Services.
9. Any prescription and non-prescription supplies (such as, ostomy supplies), devices, and

appliances other than Related Supplies.

10. Any Implantable contraceptive products are covered under the medical benefits of the EOC.
11. Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido/ and or sexual desire;
12. Any prescription vitamins (other than pre-natal vitamins), dietary supplements, herbal supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA).
13. Any drugs used for cosmetic purposes that have no medically acceptable use, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
14. Any drugs used for weight loss, weight management, metabolic syndrome; and antiobesity agents.
15. Any Injectable or infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this Plan.
16. Any medications used for travel prophylaxis, except for anti-malarial drugs.
17. Any drugs obtained outside of the United States.
18. Any fill or refill of Prescription Drugs and Related Supplies that is to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
19. Any drugs used to enhance athletic performance.
20. Any drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
21. Any prescriptions more than one year from the original date of issue.
22. Any costs related to the mailing, sending or delivery of Prescription Drugs.
23. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Member.

Prescription Drug Limitations

Each Prescription Order or refill is limited as follows:

- Up to a 30-day supply, at a Participating retail Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 30-day supply of Specialty Medications, unless limited by the drug manufacturer's packaging: or
- Up to a 90 day supply, at the subset of Participating Retail Pharmacies contracted to provide a 90-day supply for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 90-day supply of Specialty medications, unless limited by the drug manufacturer's packaging. To locate this subset of Participating Retail Pharmacies you can call the Member Services number on Your ID card or log on to www.cigna.com/ifp-providers : or
- Up to a 90-day supply at a mail-order Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 90-day supply of Specialty Medications unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

- Tobacco cessation medications included on Cigna's Prescription Drug List are limited to two 90 day supplies per Year.
    - Infusion and Injectable Specialty Prescription Medications may require Prior Authorization.
    - Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.

Pediatric Vision Care Exclusions

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

Pediatric Vision Care Limitations

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

No payment will be made for expenses incurred for:

- Services not provided by a Cigna Vision In-Network Provider;

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

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

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

J. Prior Authorization Program

Referrals to Specialists

You must obtain a Referral from Your PCP before visiting any provider other than Your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that You may make to a provider within a specified period of time. If You receive treatment from a provider other than Your PCP without a Referral from Your PCP, the treatment is not covered.

Exceptions to the Referral process:

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in “Covered Services," without a Referral from Your PCP. If Your plan covers Expanded Access Telehealth Service, You do not need a PCP referral for electronic visits with an Expanded Access Telehealth Physician.

If You are a Member under age 19, You may visit a Network Dentist for Pediatric Dental Benefits or a Network Vision Provider for Pediatric Vision Benefits without a Referral from Your PCP.

You do not need a Referral from Your PCP for Emergency Services as defined in the “Definitions." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or Your local emergency service, police or fire department for help. You do not need a Referral from Your PCP for Emergency Services, but You do need to call Your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, You should seek immediate medical attention and then as soon as possible thereafter You need to call Your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but You should, whenever possible, contact Your PCP for direction prior to receiving services.

You may also visit a qualified Participating Provider for covered Pediatric Vision Care Services and Pediatric Dental Care Services, as defined in “Covered Services”, without a referral from Your PCP.

K. Entire EOC

The EOC constitutes the entire agreement between the parties. The EOC supersedes any other prior EOCs between the parties. No agent or other person, except an officer of Cigna, has authority to waive any conditions or restrictions of the EOC; extend the time for making payment; or bind Cigna

by making any promise or representation, or by giving or receiving any information, except as otherwise provided under applicable law. No change in the EOC shall be valid unless stated in an Amendment signed by an officer of Cigna.

L. When You Have a Complaint or an Appeal

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

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

Start with Customer Service

We're here to listen and help. If You have a concern regarding a person, a service, the quality of care, or contractual benefits, You can call Us at Our toll-free number and explain Your concern to one of Our Customer Services representatives. You can also express that concern in writing. Please call Us at the Customer Services Toll-Free Number that appears on Your Cigna HealthCare ID card or Benefit Identification card, or write to:

Cigna
Individual Services
PO Box 182223
Chattanooga TN 37422

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

We'll do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We'll get back to You as soon as possible, but in any case within 30 days. If You are not satisfied with the results of a coverage decision, You can start the non-expedited appeals procedure; this timeframe does not apply to expedited appeals. You can file and expedited appeal at any time.

Appeals Procedure

Cigna has a single level appeals procedure for coverage decisions. An appeal can be filed by a Member, the Member's designee or guardian, the Member's Primary Care Physician or the Member's health care Provider. To initiate an appeal, You, or the person filing the appeal on Your behalf, must submit a request for an appeal in writing within 180 days after receipt of a denial notice, to the following address:

Cigna HealthCare of Illinois Inc.
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422
Toll Free Telephone: (866) 494-2111
Fax: (877) 815-4827
Email: NationalAppealsOrganization@Cigna.com

The deadlines indicated within this EOC for requesting an appeal or External Independent Review are not postponed or delayed by Primary Care Physician or health care Provider appeals unless your Primary Care Physician or health care Provider is acting as Your authorized representative.

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal.

If You are unable to or choose not to write, You may ask to register Your appeal by calling the toll-free number on Your Cigna HealthCare ID card or Benefit Identification card.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a review will be conducted by someone who was a) not involved in any previous decision related to Your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with Your appeal request.

We will acknowledge in writing that We have received Your request. For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For post service claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed by Us to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Us in connection with the appeal, we will provide this information to You as soon as possible and sufficiently in advance of the decision, so that You will have an opportunity to respond. Also, if any new or additional rationale is considered by Us, we will provide the rationale to You as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

The Member will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

Expedited Appeal

You can file an expedited appeal orally or in writing if:

a) the time frames under this process would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or in the opinion of his or her Physician would cause severe pain which cannot be managed without the requested services; or

b) (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If You request that Your appeal be expedited based on (a) above, You may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to Your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 24 hours, followed up in writing.

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

For expedited appeals, We will notify You within no later than 24 hours Your submission, of all information required to evaluate Your appeal. We will notify You, Your Primary Care Physician and any health care provider who recommended the health care service involved in the appeal orally with a decision within 24 hours after We receive the required information for an expedited appeal. Written notice of the determination will follow. The written notice of determination will include:

(i) reasons for the determination,

(ii) the medical or clinical criteria for the determination, and

(iii) in the case of an adverse determination, the procedures for requesting an external independent review as provided by the Illinois Health Carrier External Review Act.

External Independent Review Procedure

External Review Procedure

If You are not fully satisfied with the decision of Cigna's appeal review regarding medical necessity, experimental/investigational, initial eligibility determination, rescission of health coverage, a determination of whether You are entitled to a reasonable alternative standard for a reward under a wellness program, a determination of whether Your plan is complying with the non-quantitative treatment limitation provisions and parity in the application of medical management techniques consistent with the Mental Health Parity and Addiction Equity Act, or if a decision on Your appeal to Cigna has been delayed by Cigna for more than 30 days for concurrent or prospective appeals and 60 days for retrospective appeals, You or Your authorized representative may request that Your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity, experimental/investigational, initial eligibility determination or rescission of health coverage determination by Cigna. Administrative or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, You must send a written request to the Illinois Department of Insurance within 4 months of Your receipt of Cigna's appeal review denial. You or your authorized representative may include all relevant documentation and any additional information with Your appeal request. The Independent Review Organization will render an opinion within 45 days after receiving all necessary

information. When requested and when determined a delay would be detrimental to Your condition, the review shall be completed within 72 hours or 5 days for expedited experimental/investigational reviews.

The Independent Review Program is voluntary for You and is arranged by the Illinois Department of Insurance.

Expedited External Review Procedure

If You have a medical condition where the timeframe for completion of an expedited internal review of a grievance involving an adverse determination, a final adverse determination or a standard external review would seriously jeopardize Your life, health or ability to regain maximum function, or if a decision on Your Expedited appeal to Cigna has been delayed by Cigna for more than 48 hours, then You or Your authorized representative may file a request for an expedited external review.

You may have the right to request an expedited external review of a final adverse determination for the following:

- coverage has been denied due to Cigna's finding that the requested health care service is experimental or investigational, and Your treating physician certifies in writing, and supports the certification with evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
- an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility

To request an External Review or an Expedited External Review, You must send a request to

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767

Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Once the Illinois Department of Insurance receives Your request for external review, they will forward Your request to Cigna to determine if Your request is eligible for an external review. If Cigna determines You are ineligible for an external review, Your may appeal the decision at:

Ineligible for External Review:

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit

320 W. Washington Street
Springfield, Illinois 62767

Toll Free Telephone: (877) 527-9431
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Ineligible for Expedited External Review:

The Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, Illinois 62767

Toll Free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Appeal to the State of Illinois

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

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington Street
Springfield, IL 62767
Toll Free Telephone: (877) 527-9431
Fax: (217) 558-2083
Email: Consumer_complaints@ins.state.il.us
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided to You, Your designee or guardian, Your Primary Care Physician and the ordering health care provider, in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific Policy provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist You in the appeal

process(7) Cigna's address, toll-free phone number, fax number and appeal email address; (8) information that is specific and limited to appeals and external review procedures for Your plan; (9) information about the one level of appeal that is available; (10) the date of the adverse determination and, if applicable, the date of the final adverse determination; and (11) upon exhaustion of internal appeals by the Member, the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that You have 4 months from the date of the letter to file an external review. A final notice of adverse determination will include a discussion of the decision.

All notices will include the following contact information for the Department of Insurance:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Policy concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

In most instances, You may not initiate a legal action against Cigna until You have completed the internal appeal process.

Binding Arbitration

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

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30 day period and the 2 arbitrators so chosen shall choose a third arbitrator, who shall be an

attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a 3rd arbitrator in accordance with these requirements.
The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.
The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. The decision of the arbitrator, or the decision of any 2 arbitrators if there are 3 arbitrators, shall be binding upon both parties conclusive of the controversy in question and enforceable in any court of competent jurisdiction.
No party to this Plan shall have a right to cease performance of services or otherwise refuse to carry out its obligations under the EOC pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under the EOC.

M. Payments

Premiums and Grace Period for Members who purchased this HMO Plan Off-Marketplace

You must remit the amounts specified by Cigna, to Cigna pursuant to the EOC, for the applicable period of coverage on or before the first day of each such period of coverage. If You did not purchase Your Plan from a Marketplace, or elect to not receive advanced premium tax credit, Cigna shall permit a grace period of thirty-one (31) days during which the Premiums may be paid without loss of coverage. Coverage will continue during the grace period, however during the grace period the Subscriber shall remain liable for the payment of the premium for the time coverage was in effect during the grace period, and for any copayments owed. If premium payment is not received in full within the grace period, the EOC may be terminated by Cigna pursuant to the “Specific Causes of Ineligibility” provision of the “Eligibility” Section. In no event shall Cigna have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Members for whom the payments are actually received by Cigna shall be entitled to health care services hereunder, and then only for the period for which payment is received.

Premiums and Grace Period for Members who purchased this HMO Plan On-Marketplace

You must remit the amounts specified by Cigna, to Cigna pursuant to the EOC, for the applicable period of coverage on or before the first day of each such period of coverage. If You purchased Your Plan from a Marketplace and You have elected to receive Your advanced premium tax credit, Cigna shall permit a grace period of ninety (90) days during which the Premiums may be paid without loss of coverage. If payment is not received within the grace period, the EOC may be terminated by Cigna pursuant to the “Specific Causes of Ineligibility” provision of the “Eligibility” Section. In no event shall Cigna have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Members for whom the payments are actually received by Cigna shall be entitled to health care services hereunder, and then only for the period for which payment is received.