Cigna Health and Life Insurance Company may change the premiums of this Policy after 45 days' written notice to the Insured Person no more frequently than once in any 12 consecutive month period. However, We will not change the premium schedule for this Policy on an individual basis, but only for all Insured Persons in the same class and covered under the same plan as You. We will only change premiums on an Annual basis.

Cigna Health and Life Insurance Company
Cigna Access 6400

THIS IS A LEGAL CONTRACT
Read Your Policy Carefully

Right to Return Policy Within 10 Days Or If You Have Questions

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

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

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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This Policy was issued to You by Cigna Health and Life Insurance Company (referred to herein as Cigna) based on the information You provided in Your application, a copy of which is attached to the Policy. If, to the best of your knowledge or belief, there is any misstatement in Your application You should advise the Company immediately regarding the incorrect information; otherwise, Your Policy may not be a valid contract.

Important Cancellation Information-Please Read The Provision Entitled, "Cancellation", found in this Policy.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY AND WILL NOT DUPLICATE MEDICARE BENEFITS. This Policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim, then the amounts of benefit payable by such other medical insurance will become the deductible amount of this Policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

Guaranteed Renewable

This Policy is monthly or quarterly medical coverage subject to continual payment by the Insured Person. Cigna will renew this Policy except for the specific events stated in the Policy. However, We will not change the premium schedule for this Plan on an individual basis, but only for all Insured's in the same class and covered under the same Plan as You. **Coverage under this Policy is effective at 12:01 a.m. Eastern Time on the Effective Date shown on the Policy's specification page.**

Signed for Cigna by:

Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires the designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of your ID card.

If You have been diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition You may select a specialist who is a Participating Provider as Your Primary Care Physician.

If We determine that Your care would not be appropriately coordinated by that specialist, We may deny Your request to use that specialist as Your PCP.

For children, you may designate a pediatrician as the primary care provider.

INTRODUCTION **3**

About This Policy 3

IMPORTANT INFORMATION REGARDING BENEFITS **4**

Prior Authorization Program 4

BENEFIT SCHEDULE **6**

DEFINITIONS **20**

WHO IS ELIGIBLE FOR COVERAGE? **34**

Eligibility Requirements 34
When Can I Apply? 35
Application to Enroll or Change Coverage 35
Annual Open Enrollment Period 35
Special Enrollment Periods 35
Specific Causes for Ineligibility: 37
Continuation 37
Continuity of Care 38

HOW THE POLICY WORKS **39**

Benefit Schedule 39
Special Circumstances 40
Deductibles 40
Out of Pocket Maximum(s) 41
Special Limits 42
Penalties 42

COMPREHENSIVE BENEFITS: WHAT THE POLICY PAYS FOR **43**

Services and Supplies Provided by a Hospital or Free-Standing Outpatient Surgical Facility 43
Services and Supplies Provided by a Skilled Nursing Facility 44
Hospice Services 44
Professional and Other Services 45
Durable Medical Equipment 45
Ambulance Services 46
Services for Short-Term Rehabilitation- Physical Therapy (including Chiropractic Services and Osteopathic Services), Occupational Therapy and Speech Therapy 46
Services for Pulmonary and Cardiac Rehabilitation 47
Habilitative Services 47
Services for Mental, Emotional or Functional Nervous Disorders and Substance Use 48
Dental Care 48
Coverage of Anesthesia for Dental Procedures 48
Pregnancy and Maternity Care 49
Treatment of Infertility 49
Sexual Dysfunction Services 49
Preventive Care Services 50
Well Baby and Well Child Care 50
Newborn Hearing Benefits 50
Adult Preventive Care 51
All Other Routine Services 51
Genetic Testing 52
Bone Mass Measurement Test 52
Organ and Tissue Transplants 53
Hearing Aid Coverage 55
Positional Plagiocephaly 55
Treatment of Diabetes 56

Diagnosis and Treatment of Lymphedema 56
Treatment Received from Foreign Country Providers 56
Telehealth/Telemedicine Medical Services 56
Expanded Access Telehealth Service 57
Home Health Care 57
Mastectomy and Related Procedures 58
Breast Reconstruction and Breast Prostheses 58
Post Mastectomy Inpatient Care 58
Reconstructive Surgery 59
Congenital Treatment for Newborn Children 59
Bariatric Surgery 59
Treatment for Temporomandibular Joint Dysfunction (TMJ), and Other Disorders Of The Bones and Joints of The Jaw, Face or Head 59
External Prosthetic Appliances and Devices 60
Smoking Cessation 60
Off Label Drugs 60
Clinical Trials 61

EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY THIS POLICY 63

Excluded Services 63

PRESCRIPTION DRUG BENEFITS 68

Pharmacy Payments 68
Covered Expenses 68
Prescription Drugs and Specialty Medication Covered as Medical 69
What Is Covered 69
Conditions of Service 69
Exclusions 70
Limitations 71
Prescription Drug List Exception and Prior Authorization Process 72
Coverage of New Drugs 73
Reimbursement/Filing a Claim 73
Claims and Customer Service 74

PEDIATRIC VISION BENEFITS FOR CARE PERFORMED BY AN OPHTHALMOLOGIST OR OPTOMETRIST 75

Definitions 75
Pediatric Vision Benefits 75
What's Covered 75
Exclusions 76
Cigna Vision Providers 77
Reimbursement/Filing a Claim 77

GENERAL PROVISIONS 78

Medicare Eligibles 78
Alternate Cost Containment Provision 78
Quality Of Clinical Care Complaints 78
When You Have A Complaint Or An Appeal 78
Notice of Benefit Determination on Appeal 84
Terms of the Policy 85
Other Insurance With This Insurer 90
Opportunity to Select a Primary Care Physician 90
How to File a Claim for Benefits 91
Claim Determination Procedures 94
Claim Determination Procedures Under Federal Law (Provisions of the laws of North Carolina may supersede.) 96

PREMIUMS 99

Introduction

About This Policy

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

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

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

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE POLICY, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH OR ADOPTED CHILD OR FOSTER CHILD ADDED WITHIN 31 DAYS OF THE ADOPTION OR PLACEMENT), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER(S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL GIVE YOU 30 DAY ADVANCED NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR POLICY LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. YOU HAVE THE RIGHT TO APPEAL ANY DECISION TO RESCIND YOUR COVERAGE THROUGH THE INTERNAL APPEALS PROCESS. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEED TOTAL PREMIUMS PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE.

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

Important Information Regarding Benefits

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY. Prior Authorization can be obtained by You, Your Family Member(s) or the Provider by calling the number on the back of Your ID card.

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

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

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the hospital.

PRIOR AUTHORIZATION OF OUTPATIENT SERVICES

Prior Authorization is also required for select certain outpatient procedures and services in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO CERTAIN ELECTIVE OUTPATIENT PROCEDURES AND SERVICES MAY RESULT IN A PENALTY.

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

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

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

Retrospective Review

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

PRESCRIPTION DRUG LIST EXCEPTION and PRIOR AUTHORIZATION PROCESS

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes Prescription Drugs or Related Supplies not on Cigna's Drug List are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call, or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician can certify in writing that the Member has previously used a Prescription Drug or Related Supply that is on Cigna's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to the Member's health or has been ineffective in treating the condition and, in the opinion of the prescribing Physician, is likely to again be detrimental to the Member's health or ineffective in treating the condition. The Prior Authorization or Prescription Drug List exception will be reviewed and completed by Cigna within 72 hours of receipt. The Physician should make this request before writing the prescription.

An expedited review may be requested by the prescribing Physician when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a drug not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

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

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of this Plan, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Plan entitled "WHEN YOU HAVE A COMPLAINT OR AN APPEAL" which describes the process for the External Independent Review.

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

BENEFIT SCHEDULE

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

NOTE:

The benefits outlined in the table below show the payment for Covered Expenses. Coinsurance amounts shown below are Your responsibility after any applicable Deductible has been met, unless otherwise indicated. Copayment amounts shown are also Your responsibility. **Your actual expenses for covered services may exceed the stated coinsurance percentage amount because actual provider charges may not be used to determine plan and Insured payment obligations.**

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Medical Benefits **NOTE:** Treatment in regard to the following will be covered at the plan level for the specific service. **The following benefits are covered as mandated by North Carolina:** Lymphedema, emergency care, minimum inpatient stay following delivery of a baby, minimum benefits offered for alcoholism/drug abuse treatment, access to non-formulary drugs, hearing aids, bone mass measurement, contraceptives or devices, colorectal cancer screening, newborn hearing screening, ovarian cancer surveillance tests, prostate cancer screening, reconstructive breast surgery following a mastectomy, coverage for congenital defects and anomalies, clinical trials, anesthesia and hospital charges for dental procedures for certain individuals, diabetes, mental illness equity in benefits and minimum coverage requirement, coverage for certain off-label drug use for the treatment of cancer, TMJ joint dysfunction coverage, cardiac and pulmonary rehabilitation, orthotic device for positional plagiocephaly, organ donor search, sexual dysfunction, sterilization, blood services..		
Annual Plan Deductible	**YOU PAY:** **In-Network Deductible**	**YOU PAY:** **Out-of-Network Deductible**
Individual	$6,400	$12,800
Family	$12,800	$25,600

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Out-of-Pocket Maximum	**YOU PAY:** **In-Network Out-of-Pocket Maximum**	**YOU PAY:** **Out-of-Network Out-of-Pocket Maximum**
Individual	$7,000	$14,000
Family	$14,000	$28,000
	The following do not accumulate to the In-Network Out of Pocket Maximum; Penalties.	The following do not accumulate to the Out-of-Network Out of Pocket Maximum; Penalties.
Coinsurance	**YOU PAY:** 40%	**YOU PAY:** 50%
Prior Authorization Program		
PriorAuthorization–Inpatient Services	Your Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance.	You and Your Family Member(s) must obtain approval for inpatient admission; or You may be assessed a $500, penalty for non-compliance.
Prior Authorization – Outpatient Services **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more detailed information, excluding mandated Inpatient Hospital admissions for Complications of Pregnancy. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefit Details".	Your Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be accessed a penalty for non-compliance.	You and Your Family Member(s) must obtain approval for certain outpatient procedures and services; or You may be assessed a $60, penalty for non-compliance.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Preventive Care	**YOU PAY**	**YOU PAY**
Preventive Well Care Services		
Please refer to "Comprehensive Benefits. What the Policy Pays For" section of this Policy for additional details	0% with Deductible waived	30%
Babies/Children		
Office Visit	0% with Deductible waived	30%
Flu shot, Immunizations, Routine Lab work, and testing	0% with Deductible waived	30%
Hearing Screenings for Newborns	0% with Deductible waived	30%
Adults and Children		
Office Visits/examination related to PSA, Annual OB/GYN Exam, Pap Test, Colorectal Cancer Screening Bone Mass Measurement/Osteoporosis Screening	0% with Deductible waived	30%
Routine Preventive Care (including Mammogram, PSA Screening, Pap Test, Colorectal Cancer Screening, Bone Mass Measurement/Osteoporosis Screening	0% with Deductible waived	30%
All Other Routine Services		
Routine Physicals to include Immunizations, flu shots, and routine lab work and testing	0% with Deductible waived	30%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist For Insured Persons 19 years of age *Please be aware that the Pediatric Vision network is different from the network of your medical benefits	**YOU PAY:**	**YOU PAY:**
Comprehensive Eye Exam and Refraction for Children Limited to one exam per year	0% per exam, Deductible waived	40% per exam, Deductible waived
Eyeglasses and Lenses for Children		
Frames	0% per pair, Deductible waived	40% per pair, Deductible waived
Single Vision	0% per pair, Deductible waived	40% per pair, Deductible waived
Lined Bifocal	0% per pair, Deductible waived	40% per pair, Deductible waived
Lined Trifocal	0% per pair, Deductible waived	40% per pair, Deductible waived
Lenticular	0% per pair, Deductible waived	40% per pair, Deductible waived
Contact lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses **Contact Lenses for Children**		
Elective	0% per pair, Deductible waived	40% per pair, Deductible waived
Therapeutic	0% per pair, Deductible waived	40% per pair, Deductible waived
Limited to one pair per year		
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit		

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Physician Services	**YOU PAY:**	**YOU PAY:**
Office Visit (including allergy testing and treatment/injections and lab and x-ray tests and surgery done in the office) Also includes Home Visits		
Primary Care Physician (PCP)	40%	50%
Specialist, (including consultant, referral and second opinion services)	40%	50%
Expanded Access Telehealth Service 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%	50%
Physician Services, continued	**YOU PAY:**	**YOU PAY:**
Surgery in Physician's office	40%	50%
Outpatient Professional Fees for Surgery(including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy	40%	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	40%	50%
In-Hospital visits	40%	50%
Allergy testing and treatment/injections	40%	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Hospital Services	**YOU PAY:**	**YOU PAY:**
Inpatient Hospital Services		
Facility Charges	40%	50%
Professional Charges	40%	50%
Emergency Admissions		In-network benefit level for an Emergency Medical Condition, otherwise 50%
Facility Charges	40%	
Professional Charges	40%	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	**YOU PAY:** 40%	**YOU PAY:** 50%
Emergency Services	**YOU PAY:**	**YOU PAY:**
Emergency Room *Coverage includes services not otherwise covered which are required as a direct result of emergency medical treatment, until patient is stabilized.*	40%	In-network benefit level for an Emergency Medical Condition, otherwise 50%
Ambulance *Emergency transportation to the nearest facility, if such facility is not equipped to provide necessary treatment further transportation is provided*	40% for Ground or Air transport.	In-network benefit level for an Emergency Medical Condition, otherwise 50% for Ground or Air transport.
Urgent Care	**YOU PAY:** 40%	**YOU PAY:** In-network benefit level for an Emergency Medical Condition, 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation charges	**YOU PAY:** 40%	**YOU PAY:** 50%
All Other Laboratory and Radiology Services Facility and interpretation charges **Physician's Office** **Free-Standing/Independent lab or x-ray lab facility** **Outpatient Hospital lab or x-ray**	**YOU PAY:** 40% 40% 40%	**YOU PAY:** 50% 50% 50%
Short-Term Rehabilitation Services-Physical, Occupational, and Chiropractic Services Maximum of 30 visits per Insured Person, per calendar year for all therapies, In- and Out-of-Network combined.	**YOU PAY:** 40%	**YOU PAY:** 50%
Short-Term Rehabilitation Services-Speech Therapy Maximum of 30 visits per Insured Person, per calendar year, In- and Out-of-Network combined.	**YOU PAY:** 40%	**YOU PAY:** 50%
Cardiac & Pulmonary Rehabilitation Cardiac Rehabilitation maximum of 30 visits per Insured Person, per Calendar Year In- and Out-of-Network combined. Limits based on Medical Necessity guidelines Note: Pulmonary Rehabilitation maximum benefit of 1 course per Calendar Year.	**YOU PAY:** 40%	**YOU PAY:** 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD), and Other Disorders Related to the Bones or Joints of the Jaw, Face or Head	**YOU PAY:** 40%	**YOU PAY:** 50%
Habilitative Services Maximum of 30 visits per Insured Person, per calendar year for all therapies. In- and Out-of-Network combined.	**YOU PAY:** 40%	**YOU PAY:** 50%
Women's Contraceptive Services, Family Planning and Sterilization	**YOU PAY:** No charge, Deductible waived	**YOU PAY:** 30%
Male Sterilization	**YOU PAY:** Copay or Coinsurance applies for specific benefit provided	**YOU PAY:** 50%
Maternity (Pregnancy and Delivery)/Complications of Pregnancy	**YOU PAY:**	**YOU PAY:**
Initial Office Visit to confirm pregnancy	40%	50%
Prenatal services, Postnatal and Delivery (billed as "global" fee)	40%	50%
Hospital Delivery charges	40%	50%
Prenatal testing or treatment billed separately from "global" fee	40%	50%
Postnatal visit or treatment billed separately from "global" fee	40%	50%
Infertility	**YOU PAY:** 40%	**YOU PAY:** 50%
Sexual Dysfunction	**YOU PAY:** 40%	**YOU PAY:** 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of *60 days per Insured* Person, per Calendar Year combined In- and Out-of-Network for all facilities listed.	**YOU PAY:** 40%	**YOU PAY:** 50%
Home Health Services *Maximum 16 hours per day* *Maximum 8 visits per day*	**YOU PAY:** 40%	**YOU PAY:** 50%
Durable Medical Equipment	**YOU PAY:** 40%	**YOU PAY:** 50%
Prosthetic Devices	**YOU PAY:** 40%	**YOU PAY:** 50%
Orthotic Devices for Positional Plagiocephaly	**YOU PAY:** 40%	**YOU PAY:** 50%
Hearing Aids Limited to one hearing aid per each hearing-impaired ear every 36 months. For detailed information refer to the section of the Policy titled 'Comprehensive Benefits: What The Policy Pays For.'	**YOU PAY:** 40%	**YOU PAY:** 50%
Hospice *Inpatient* *Outpatient*	**YOU PAY:** 40% 40%	**YOU PAY:** 50% 50%
Dialysis Inpatient Hospital Services benefit applies **Inpatient** **Outpatient**	**YOU PAY:** 40% 40%	**YOU PAY:** 50% 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Diabetes (treatment, supplies, education and training)	**YOU PAY:** 40%	**YOU PAY:** 50%
Smoking Cessation **Medical treatment** Maximum of 2 courses of treatment per Year (Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit)	**YOU PAY:** 0%, Deductible waived	**YOU PAY:** 30%
Nutritional and Genetic Counseling ▪ Maximum: 6 days Nutritional Counseling and 3 days Genetic Counseling per calendar year *Services for Diabetes, Mental Health or Substance Use Disorder diagnosis are unlimited and do not contribute to the day maximum*	**YOU PAY:** 0%, Deductible waived	**YOU PAY:** 30%, Deductible waived
Diagnosis and Treatment of Lymphedema	**YOU PAY:** 40%	**YOU PAY:** 50%
Coverage of Clinical Trials	**YOU PAY:** 40%	**YOU PAY:** 50%
Mental, Emotional or Functional Nervous Disorders *Inpatient (Includes Acute and Residential Treatment)* *Outpatient (Includes individual, group, intensive outpatient, and partial hospitalization)* *Office Visit* *All Other Outpatient Services*	**YOU PAY:** 40% 40% 40% 40%	**YOU PAY:** 50% 50% 50% 50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Substance Use Disorder	**YOU PAY:**	**YOU PAY:**
Inpatient Rehabilitation (Includes Acute and Residential Treatment)	40%	50%
Outpatient(Includes individual, group, intensive outpatient and partial hospitalization)	40%	50%
Office Visit	40%	50%
All Other Outpatient Services	40%	50%
Bariatric Surgery	**YOU PAY**	**YOU PAY**
Office visits for the evaluation and treatment of obesity are limited to a combined In and Out of Network maximum of four (4) visits per Calendar Year. ***(See benefit detail in the "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)***	40%	50%
Organ and Tissue Transplants	**YOU PAY:**	**YOU PAY:**
(See benefit detail in the "Comprehensive Benefits, What the Plan Pays For" for covered procedures and other benefit limits which may apply.)		
Cigna LIFESOURCE Transplant Network® Facility	0%	NOT APPLICABLE
Other Cigna Network Facility Contracted to Provide Transplant Benefits	40%	NOT APPLICABLE
Out-of-Network Facility	NOT APPLICABLE	50%
Travel Benefit: Cigna LIFESOURCE Transplant Network® Facility:	0%	NOT APPLICABLE

BENEFIT INFORMATION Note: Covered Services are subject to applicable Annual Deductible unless specifically waived.	IN-NETWORK–YOU PAY (Based on Cigna the Negotiated Rate) AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS , ARE THE INSURED PERSON'S RESPONSIBILITY	OUT-OF-NETWORK–YOU PAY (Based on Maximum Reimbursable Charge) COINSURANCE AMOUNTS SHOWN BELOW, INCLUDING DEDUCTIBLE(S), COINSURANCE, COPAYMENTS, ARE THE INSURED PERSON'S RESPONSIBILITY
Travel Benefit: Other Cigna Network Facility Contracted to Provide Transplant Benefits:	40%	NOT APPLICABLE
Travel Benefit: Out-of-Network Facility	NOT APPLICABLE	50%
Donor Search Benefit: Cigna LIFESOURCE Transplant Network® Facility:	0%	NOT APPLICABLE
Donor Search Benefit: Other Cigna Network Facility Contracted to Provide Transplant Benefits:	40%	NOT APPLICABLE
Donor Search Benefit: Out-of-Network Facility	NOT APPLICABLE	50%
Infusion and Injectable Special Prescription Medications and related services or supplies	**YOU PAY:** 40%	**YOU PAY:** 50%
Dental Care (other than Pediatric) Limited to treatment for accidental injury to the natural teeth within six months of the accidental injury	**YOU PAY:** 40%	**YOU PAY:** 50%
Dental Treatment in Hospital or Ambulatory Surgical Center- (For Insured Person's or Insured Person's with serious mental or physical conditions. For detailed information refer to the section of the Policy titled 'Comprehensive Benefits: What The Policy Pays For.')	**YOU PAY:** 40%	**YOU PAY:** 50%

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Prescription Drugs Benefits		
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" Coinsurance shown in the Benefit Schedule.		
Prescription Drug Deductible	Integrated Medical and Prescription Drug Deductible	
Cigna Retail Pharmacy Drug Program		
Tier 1: Retail Preferred Generic Up to a 90 day maximum supply	50% per prescription or refill	50% per prescription or refill
Tier 2: Retail Non-Preferred Generic Up to a -90 day maximum supply	50% per prescription or refill	50% per prescription or refill
Tier 3: Retail Preferred Brand Up to a 90 day maximum supply	50% per prescription or refill	50% per prescription or refill
Tier 4: Retail Non-Preferred Brand Up to a 90 day maximum supply	50% per Prescription or refill	50% per prescription or refill
Tier 5: Retail Specialty Up to a 90 day maximum supply	50% per prescription or refill	50% per prescription or refill
Retail Pharmacy **Preventive Drugs regardless of Tier** Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive (including women's' contraceptives) that are: • Prescribed by a Physician • Generic or Brand Name with no Generic alternative Up to a 90 day maximum supply	0% Deductible waived per Prescription or refill	50% per Prescription or refill

BENEFIT INFORMATION	IN-NETWORK – YOU PAY (Based on Cigna contract allowance)	OUT-OF-NETWORK YOU PAY (Based on Maximum Reimbursable Charge)
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
Cigna Mail Order Pharmacy Drug Program		
Tier 1: Mail Order Preferred Generic Up to a 90 day maximum supply	50% per prescription or refill	50% per Prescription or refill
Tier 2: Mail Order Non-Preferred Generic Up to a 90 day maximum supply	50% per prescription or refill	50% per Prescription or refill
Tier 3: Mail Order Preferred Brand Up to a 90 day maximum supply	50% per prescription or refill	50% per Prescription or refill
Tier 4: Mail Order Non-Preferred Brand Up to a 90 day maximum supply	50% per Prescription or refill	50% per Prescription or refill
Tier 5: Mail Order Specialty Up to a 90 day maximum supply	50% per prescription or refill	50% per Prescription or refill
Mail Order Pharmacy **Preventive Drugs regardless of Tier** **Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive** **(including women's' contraceptives that are:** • Prescribed by a Physician • Generic or Brand Name with no Generic alternative) Up to a 90 day maximum supply	0% Deductible waived per Prescription or refill	50% per Prescription or refill

Definitions

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

Acceptable Third Party Payor means one or more of the following:

1. the Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
2. an Indian tribe, tribal organization, or urban Indian organization;
3. a State or Federal government program; or
4. an independent private entity that (i) is organized as a not-for-profit organization under State law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of Your financial need and does not in any way consider the health status of any Insured Person in determining whether to make such payments on Your behalf.

Annual, Calendar Year, Year is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

Annual Open Enrollment Period means the designated period of time during each Calendar Year, when individuals can apply for coverage for the following Year. The Annual Open Enrollment Period is set by the federal government, and the beginning and ending dates are subject to change each Year.

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

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

Coinsurance means the percentage of Covered Expenses the Insured Person is responsible for paying after applicable Deductibles are satisfied). **Coinsurance does not include Copayments. Coinsurance also does not include charges for services that are not Covered Services or charges in excess of Covered Expenses, or charges which are not Covered Expenses under this Policy.**

Copayment/Copay is a set dollar amount of Covered Expenses the Insured Person is responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses. Copayments are calculated separately from Coinsurance.

Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Cosmetic Surgery Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Coverage Area is any place that is within the state of North Carolina within the counties, cities and/or zip code areas in the state of North Carolina that Cigna has designated as the area where this Plan is available for enrollment.

Covered Expenses are the expenses incurred for Covered Services under this Policy for which Cigna will consider for payment under this Policy. Covered Expenses will never exceed the Negotiated Rate for Participating Providers nor will they exceed Maximum Reimbursable Charges for Non-Participating Providers. In addition, Covered Expenses may be limited by other specific maximums described in this Policy. Covered Expenses are subject to applicable Deductibles and other benefit limits. **An expense is incurred on the date the Insured Person receives the service or supply.** Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that:

a. are listed in the benefit sections of this Policy, and

b. are not specifically excluded by the Policy, and

c. are provided by a Provider that is:

(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 another appropriately licensed organization, and

(iii) acting within the scope of the practitioner's license and accreditation.

Creditable Coverage is coverage under any of the following:

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

Custodial Care is any service that is of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in performing activities of daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) eating, (g) preparing foods, or (h) taking medications that can be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

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

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

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

Diabetes Self-Management Training is instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as means of avoiding frequent hospitalization and complications.

Diabetes Pharmaceuticals & Supplies include, but are not limited to, test strips for blood glucose monitors; visual reading and urine test strips; tablets which test for glucose, ketones and protein; blood glucose monitors on Cigna's Prescription Drug List, lancets and lancet devices; insulin and insulin analogs, injection aids; including devices used to assist with insulin injection and needle less systems; syringes and needles, biohazard disposal containers, prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Durable Medical Equipment is defined as items which:

- are designed for and able to withstand repeated use by more than one person;
- customarily serve a therapeutic purpose with respect to a particular Illness or Injury, as certified in writing by the attending medical provider;
- generally are not useful in the absence of illness or injury;
- are appropriate for use in the home;
- are of a truly durable nature, and
- are not disposable.

Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines.

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

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

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

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

Essential Health Benefits means, to the extent covered under the plan, expenses incurred with respect to Covered Services, in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, Mental Health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Expanded Access Telehealth Physician means a Physician who is part of a designated telehealth network, an organization contracted with Cigna to provide specific telehealth services.

Expanded Access Telehealth Service means a telehealth visit, initiated by the Insured Person and provided by an Expanded Access Telehealth Physician, for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Note: the network that provides Expanded Access Telehealth Service is separate from the Plan network, and is only available for services detailed under “Expanded Access Telehealth Service” in the “Covered Services and Benefits” section of this Plan.

Experimental / Investigational Procedures a drug, device or medical treatment or procedures is considered Experimental or Investigational if;

- it has not been demonstrated through existing peer-reviewed, evidence based scientific literature to be safe and effective for treating or evaluating the condition or illness for which it is proposed; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or under study to determine if maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the state or means of treatment or diagnosis; or
- reliable evidence shows that the consensus of the opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with the stated means of treatment of diagnosis.

Reliable evidence means only; the published reports and articles in authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure; or the medical informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

Family In-Network Deductible applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual In-Network Deductible amount toward the Family In-Network Deductible. The Individual In-Network Deductible paid by each Family Member counts towards satisfying the Family In-Network Deductible. Once the Family In-Network Deductible amount is satisfied, the remaining Individual In-Network Deductibles will be waived for the remainder of the Year. The amount of the Family In-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family In-Network Out-of-Pocket Maximum: The Family In-Network Out-of-Pocket Maximum is an accumulation of Covered Expenses incurred from Participating Providers that applies if You cover other Family Member(s). The Individual In-Network Out-of-Pocket paid by each Family Member counts toward satisfying the Family In-Network Out-of-Pocket Maximum. Each Insured Person can contribute up to the Individual In-Network Out-of-Pocket amount toward the Family In-Network Out-of-Pocket maximum. The per person cost limitations will not exceed the amount for an Individual. Once the Family In-Network Out of Pocket Maximum has been met for the Year, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family In-Network Out of Pocket Maximum and will always be paid by You. The amount of the Family In-Network Out-of-Pocket Maximum is described in the Schedule of Benefits section of this Policy.

Family Member means Your spouse, children or other persons eligible for coverage under this Policy because of their relationship with You. Family Members who may be eligible for coverage under this Policy are described further in the section of the Policy titled “Who is Eligible for Coverage?”

Family Out-of-Network Deductible applies if You cover other Family Member(s). Each Insured person can contribute up to the Individual Out-of-Network Deductible amount toward the Family Out-of-Network Deductible. The Individual Out-of-Network Deductible paid by each Family Member counts towards satisfying the Family Out-of-Network Deductible. Once the Family Out-of-Network Deductible amount is satisfied, the remaining Individual Out-of-Network Deductibles will be waived for the remainder of the Year. The amount of the Family Out-of-Network Deductible is described in the Schedule of Benefits section of this Policy.

Family Out-of-Network Out of Pocket Maximum: applies if You cover other Family Member(s). Each Insured Person can contribute up to the Individual Out-of-Network Out-of-Pocket amount toward the Family Out-of-Network Out-of-Pocket maximum. The per person cost limitations will not exceed the amount for an Individual. Once the Family Out-of-Network Out of Pocket Maximum has been met for the Year for Covered Services received from Non-Participating Providers, You and your Family Member(s) will no longer be responsible to pay Coinsurance for medical services for Covered Expenses incurred during the remainder of that Year from Non-Participating Providers. Non-compliance penalty charges do not apply to the Family Out-of-Network Out of Pocket Maximum and will always be paid by You. The Family Out-of-Network Out of Pocket Maximum is an accumulation of Covered Expenses incurred from Non-Participating Providers. The amount of the Family Out-of-Network Out of Pocket Maximum is described in the Schedule of Benefits section of this Policy

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

Free-Standing Outpatient Surgical Facility: The term Free-Standing Outpatient Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

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

Habilitative Services are those services that are

- Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (Habilitative Services).
- These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- Are individualized and there is a documentation outlining quantifiable, measurable and attainable treatment goals.

Home Health Agencies and Visiting Nurse Associations are home health care providers that are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in Your home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospice Care Program means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the Illness; a program for persons who have a Terminal Illness and for the families of those persons.

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

Hospital means

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or
- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a hospital for the appropriate treatment and/or diagnosis by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of mental health and substance use disorder or other related Illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency;

The term Hospital will not include any institution or facility in which a significant portion of the activities include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services.

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

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

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

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

Infertility is the inability after 12 consecutive months of unsuccessful attempts to conceive a child despite regular exposure of female reproductive organs to viable sperm.

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

Injury means an accidental bodily injury.

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

Institution means an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

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

Marketplace means a state-based Marketplace, a state partnership Marketplace, or a federally-facilitated Marketplace, as the case may be.

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

- A percentile or percentage of 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 In-Network Cigna 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.

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

- The provider's normal charge for a similar service or supply; or
- A percentile and or percentage of 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 In-Network Cigna 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 he geographic market

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

Medically or Dentally Necessary means the services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the Member, the Member's family, or the provider.
- For Medically Necessary services, We compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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

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

Negotiated Rate is the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn is an infant from birth to 31 days of birth.

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

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

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

Benefits are also provided for a Physician's visit to the Insured Person's home.
This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

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

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

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

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

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

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

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

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

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

Physician is a Physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state in which the Insured Person resides; and provides services covered by the Policy that are within the scope of his or her licensure.

Policy is the set of benefits, conditions, exclusions, limitations, and premiums described in this document, including the Policy specification page, the completed and accepted application for coverage attached to this Policy, and any amendments or endorsements to this document. Your Policy is also referred to herein as the Plan or this Plan.

Policyholder means the applicant who has applied for, been accepted for coverage, and who is named as the Policyholder on the specification page.

Policy Year is defined as a 12-month period that begins each January 1 at 12:01 a.m. Eastern Time.
Note; Deductible and other benefit accumulations accumulate on a Calendar Year rather than Policy Year basis.

Positional Plagiocephaly is the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

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

Prescription Drug List is a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated. The Prescription Drug List is available upon request. You can view the drug list on www.myCigna.com.

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

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

Prior Authorization means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Cigna for medical services and from the Pharmacy and Therapeutics Committee for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are Prescribed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this Plan. You can identify the Prescription Drugs and Related Supplies that require Prior Authorization on the Prescription Drug List at www.myCigna.com.

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

Prostheses/Prosthetic Appliances and Devices are fabricated replacements for missing body parts. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:

- basic limb prostheses; and
- terminal devices such as hands or hooks

Provider means a Hospital, a Physician or any other health care practitioner (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.

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes, "breast reconstruction". For the purpose of this Policy, breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

Related Supplies are diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for self-injectables outpatient prescription drugs that are not dispensed in pre-filled syringes, inhalers, inhaler spacers for the management and treatment of pediatric asthma and other conditions, diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills); disposable needles and syringes needed for injecting covered drugs and supplements.

Restricted Access Drug or Device means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

Self-administered Injectable Drugs means FDA approved medications which a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection. This does not include insulin prescribed for use by the Insured Person.

Service Area is any place where you live, work, reside that is within the cities, counties and/or zip code areas in the state of North Carolina that Cigna has designated as the Service Area for this Plan, as described in the Provider Directory applicable to this Policy. For specific information regarding Your Service Area please check the Provider Directory to locate a Provider who is participating in the Network used by this Plan, call the toll-free number on the back of Your ID card, or check www.mycigna.com and click on "find a Doctor, Dentist or Facility".

Sexual Dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must:

- be an institution licensed and operated pursuant to law, and
- be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician, and
- provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.), and
- maintain a daily medical record on each patient.

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or educational care.

Smoking Cessation Attempt means 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and over-the-counter medications with a Physician's prescription) for a 90-day treatment regimen. Please see your Prescription Drug List for details.

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

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

Specialty Medication means a Generic or Brand Name Prescription Drug that meets both of the following criteria, subject to applicable law:

(A) The drug is either derived from biotechnology processes, which use tissue culture, living cells, or cellular enzymes; or is a small molecule drug (organic compound, binds to a protein, nucleic acid, or polysaccharide); and

(B) In general meets at least 3 of the following attributes:

1. Targets the underlying disease pathology;
2. Modifies disease sequel;
3. Targets conditions that are rare, chronic, and costly;
4. Requires close supervision and monitoring of therapy for safety and effectiveness;
5. There is an available genetic test to ascertain its efficacy within a defined population.

The fact that a drug is considered a Specialty Medication based on the above criteria does not necessarily determine the tier assignment of the Specialty Medication, or whether the Specialty Medication is covered under the medical benefit or prescription drug benefit of this Policy.

Stabilize means with respect to an Emergency Medical Condition, to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of Hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including Medically Necessary services and supplies to maintain stabilization until the Insured is transferred.

Step Therapy is a type of Prior Authorization. Cigna may require an Insured Person to follow certain steps before covering some Prescription Drugs and Related supplies, including Specialty Medications. We may also require an Insured Person to try similar Prescription Drugs and Related Supplies, including Specialty Medications that have been determined to be safe, effective, and more cost effective for most people that have the same condition as the Insured Person. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.myCigna.com.

Telemedicine Medical Service is a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of advanced telecommunications technology.

Terminal Illness is an illness due to which a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

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

Eligibility Requirements

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

You are eligible for coverage under this Policy if, at the time of application:

You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and

You are a resident of the state of North Carolina; and

- You live, work or reside in the Coverage Area in which You are applying and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges and You do not reside in an Institution; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.

Other Insured Persons may include the following Family Member(s):

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's children, regardless of age, enrolled prior to age 26, who are incapable of self-support due to medically certified continuing intellectual or physical disability and are chiefly dependent upon the Insured for support and maintenance. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday. Periodically thereafter, but not more often than annually, Cigna may require written proof of such disability or dependency.
- Your own, or Your spouse's newborn children are automatically covered for the first 31 days of life. To continue coverage past that time if additional premium is required You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 61 days of birth will be retroactive to the date of the child’s birth. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child’s birth, or the first date of coverage under this Plan, whichever is later.
- An adopted child, including a child who is placed with you for adoption, is automatically covered for 31 days from the date of the adopted child’s placement for adoption or initiation of a suit of adoption. To continue coverage past that time if additional premium is required You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 61 days of adoption will be retroactive to the date of the child’s placement for adoption or initiation of a suit of adoption. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child’s placement for adoption or initiation of a suit of adoption, or the first date of coverage under this Plan, whichever is later.

- A foster child is automatically covered for 31 days from the date of placement in Your residence. To continue coverage past that time if additional premium is required You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of placement in the home, and pay any additional premium. Coverage for a foster child dependent enrolled within 61 days of the placement in the home will be retroactive to the date of the child's placement for foster care. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's placement for foster care, or the first date of coverage under this Plan, whichever is later.
- If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic following the date on which the court order is issued. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a dependent within 61 days of the date of adoption, and pay any additional premium. Coverage for a court ordered dependent child enrolled within 61 days of court order will be retroactive to the date of the court order. Enrollment is allowed per application by the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program.

When Can I Apply?

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an eligible person must enroll for coverage or change plans during the annual Open Enrollment Period. Persons who fail to enroll or change plans during the Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and an Insured Person can add dependents and change coverage.

The Open Enrollment Period and Special Enrollment Period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time each Year during which Individuals who are eligible as described above can apply to enroll for coverage or change coverage from one plan to another.

To be enrolled for coverage under this Plan. You must submit a completed and signed application for coverage under this Policy for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this Policy will then become effective upon the earliest day allowable under federal rules for that Year's Open Enrollment Period. Note: If You do not apply to obtain or change coverage during the Annual Open Enrollment Period, You will not be able to apply again until the following Year's Annual Open Enrollment Period unless You qualify for a special enrollment period as described below.

Special Enrollment Periods

A special enrollment period occurs when a person experiences a triggering event.

If You experience one of the triggering events listed below, You can enroll for coverage and enroll Your eligible Dependent(s) during a Special Enrollment Period instead of waiting for the next Annual Open Enrollment Period.

Triggering events for a special enrollment period are:

An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or

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

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

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

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care. Under PPACA special enrollment period guidelines the qualified individual or enrollee may elect a coverage effective date of the first day of the month following the date of the event, OR elect a regular effective date. If the qualified Individual or enrollee does not elect a delayed effective date then the "default" will be the date of birth for a newborn, adoption, or placement in the home for an adopted or foster child.

- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility:

Except as described in the Continuation section, an Insured Person will become ineligible for coverage under the Policy:

- Nonpayment of premiums – The Individual has failed to pay premiums in accordance with the terms of the Policy or the health insurer has not received timely premium payments.
- Fraud – The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy.
- Termination of plan – The health insurer is ceasing to offer coverage in the individual market.
- Movement outside service area – In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer works, resides, lives in the service area (or in an area for which the health insurer is authorized to do business) but only if the coverage is terminated without regard to any health status related factor of covered individuals.

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

Continuation

If an Insured Person's eligibility under this plan would terminate due to the Insured's death, divorce or if other Insured Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this Plan; except for the Insured's failure to pay premium, that Member has the right to continuation of his or her insurance. Coverage will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this Agreement would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

Continuity of Care

There may be instances in which Your PCP or network specialist ceases to be a Participating Physician. In such cases, You will be notified and provided assistance in selecting a new PCP or identifying a new network specialist to continue providing Covered Services. However, in special circumstances, You may be able to continue seeing Your PCP or network specialist, even though he or she is no longer affiliated with Cigna.

Continuity of Care allows You to receive services at In-network coverage levels if Your PCP is leaving the network and You (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered Your second trimester of pregnancy as of the effective date of Your enrollment. You may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to ninety (90) days, or the post-partum period directly related to the delivery of Your child. Such continuity of care must be approved in advance by Cigna, and Your doctor must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider who ceases to be a Participating Provider will not be available, such as when the provider loses his/her license to practice or retires.

If Your request for continuity of care is denied, You can follow the internal and external appeals procedure detailed in the section titled When You Have a Complaint or An Appeal.

How The Policy Works

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

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

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

Benefit Schedule

The Benefit Schedule shows the maximum Covered Expense for each type of benefit.

No benefits are payable unless the Insured Person’s coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Policy.

Participating Hospitals, Participating Physicians and Other Participating Providers

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

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

Non-Participating Hospitals, Non-Participating Physicians, and Other Non-Participating Providers

Covered Expense for services provided by a Non-Participating Provider will not exceed the lesser of actual billed charges, or a Maximum Reimbursable Charge. These services may be subject to additional penalties and/or Deductibles.

Special Circumstances

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

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

- **Physician or Other Provider Emergency Services**

  Covered Expense will be paid at the Participating Provider benefit schedule for the initial care of an Emergency Medical Condition.

- **Availability of Preferred Providers**

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

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Insured Person must pay before benefits are available. Deductibles apply to all Covered Expenses as described in the Definitions section of this Policy, unless expressly stated otherwise in the Benefit Schedule. Deductibles do not include any amounts in excess of Maximum Reimbursable Charges, any penalties, or expenses that are not Covered Expenses.

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

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

In-Network Deductible

The In-Network Deductible is stated in the Benefit Schedule. The Deductible is the amount of Covered Expenses You must pay for **any** Covered Services (except as otherwise specifically stated in the Benefit Schedule) incurred from Participating Providers each Year before any benefits are available. If You cover other Family Member(s), the Family In-Network Deductible will apply. Each Insured Person can contribute up to the individual In-Network Deductible amount toward the Family In-Network Deductible. Once this Family In-Network Deductible is satisfied, no further Family In-Network Deductible is required for the remainder of that Year.

Out-of-Network Deductible

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

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

Out of Pocket Maximum(s)

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

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

Special Limits

We will only apply the Special Limit amount to any Deductible. Even when an Out of Pocket Maximum is reached, We will still apply the Special Limits on certain Covered Expenses described in the Benefit Schedule. Please see the Benefit Schedule for details on visit, day or event maximums which may apply to these specific Benefits.

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

Penalties

A Penalty is an amount of Covered Expenses that is:

- Not counted toward any Deductible;
- Not counted toward the Out of Pocket Maximum(s);
- Not eligible for benefit payment once the Deductible is satisfied.

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

Penalties will apply under the following circumstances:

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

Penalties are applied before any benefits are available.

Comprehensive Benefits: What the Policy Pays For

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

To be eligible for benefits under this Policy, the Provider must be appropriately licensed according to state and local laws and accredited to provide services within the scope of the Provider's license and accreditation.

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

The benefits described in this section will be paid for Covered Expenses incurred on the date You and Your Family Member(s) receive the service or supply for which the charge is made. These benefits are subject to all terms, conditions, Deductibles, penalties, exclusions, and limitations of this Policy. All services will be paid at the percentages indicated in the Schedule of Benefits and subject to limits outlined in the section entitled "How the Policy Works".

Following is a general description of the supplies and services for which the Participating Provider Policy will pay benefits if such services and supplies are Medically Necessary and for which You are otherwise eligible as described in this Policy.

If You are an inpatient in a Hospital, Skilled Nursing Facility or inpatient rehabilitation facility on the day Your coverage begins, We will pay benefits for Covered Services that You receive on or after Your first day of coverage related to that inpatient stay as long as You receive Covered Services in accordance with the terms of this Policy. These benefits are subject to any prior carrier's obligations under state law or contract.

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

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

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

- Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.
- Outpatient services and supplies including those in connection with Emergency Services, outpatient surgery and outpatient surgery performed at a Free-Standing Outpatient Surgical Facility.
- Diagnostic/Therapeutic Lab and X-rays.
- Anesthesia and Inhalation Therapy.

Payments of Inpatient Covered Expenses are subject to these conditions:

- Services must be those which are regularly provided and billed by the Hospital or Free-Standing Outpatient Surgical Facility.
- Services are provided only for the number of days required to treat the Insured Person's Illness or Injury.

  Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Services and Supplies Provided by a Skilled Nursing Facility

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

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

- Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.
- Payment of benefits for Skilled Nursing Facility services is subject to all of the following conditions:
- You and Your Family Members must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
- You and Your Family Members must remain under the active medical supervision of a Physician treating the Illness or Injury for which You and Your Family Members are confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

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

Hospice Services

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

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

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

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

Professional and Other Services

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

This Policy provides benefits for Covered Expenses incurred for:

- Services of a Physician;
- Services of an anesthesiologist or an anesthetist;
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;
- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Prostheses/Prosthetic appliances and devices, artificial limbs or eyes;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
- The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery;
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products;
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization or pre-certification

Durable Medical Equipment

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

This Policy provides benefits for Covered Expenses incurred for rental or purchase of medical equipment and/or supplies that meet all of the following requirements:

- Are ordered by a Physician;
- Are of no further use when medical need ends;
- Are not primarily for comfort or hygiene;
- Are not for environmental control;
- Are not for exercise; and
- Are manufactured specifically for medical use.

Note: Medical equipment and supplies must meet all of the above guidelines in order to be eligible for benefits under this Policy. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative.

Cigna determines whether the item meets these conditions and whether the equipment falls under a rental or purchase category.

Rental charges that exceed the reasonable purchase price of the equipment are not covered, unless the equipment as previously been determined by Cigna to fall into a continuous rental category and require frequent maintenance and servicing.

Ambulance Services

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

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

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

Ambulance transportation is covered for emergency situations, to the nearest facility capable of handling the emergency or Medically Necessary transfers from one medical facility to another only.

Services for Short-Term Rehabilitation- Physical Therapy (including Chiropractic Services and Osteopathic Services), Occupational Therapy and Speech Therapy

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

This Policy provides benefits for Covered Expenses incurred for the following short-term rehabilitative services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury
- Services for the necessary care and treatment of loss or impairment of speech.

Benefits are provided up to any maximum number of visits shown in the Benefit Schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

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

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

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

Services for Pulmonary and Cardiac Rehabilitation

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

This Policy provides benefits for Covered Expenses incurred for pulmonary rehabilitation and for:

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary.
- Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge.
- The Phase II program must be Physician directed with active treatment and EKG monitoring.

Note: Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Habilitative Services

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

This Policy provides benefits for Covered Expenses designed to assist You ~~to~~ in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame. Covered Expenses are payable as stated in the Benefit Schedule.

Services may include:

- Physical Therapy; or
- Occupational Therapy; or
- Speech Therapy; or
- Cognitive skills therapy.

Benefits are provided up to any maximum number of visits shown in the Benefit Schedule. For the purposes of this benefit, the term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

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

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

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

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

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

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

Dental Care

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

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

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

Coverage of Anesthesia for Dental Procedures

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

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center for:

- an Insured Person who is a child under the age of 9;
- an Insured Person at any age who is developmentally disabled; or
- an Insured Person whose health is compromised and general anesthesia is Medically Necessary.

Pregnancy and Maternity Care

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

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

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

The mother and her newborn child shall be entitled to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. If a decision is made between a mother and doctor to discharge a mother or newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

This Policy provides benefits for complications of pregnancy. Benefits are available for other pregnancy and maternity care as indicated above under "Pregnancy and Maternity Care".

We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization for prescribing a length of stay that does not exceed the above periods. However, We may provide benefits for a shorter stay if the attending provider (e.g., the Physician, nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Treatment of Infertility

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

This Policy provides benefits for Covered Expenses including services to diagnose and treat conditions resulting in infertility. Please note: treatment for Infertility, such as in vitro fertilization and other types of artificial or surgical means of conception and associated procedures and the related medications are not covered.

Sexual Dysfunction Services

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

This Policy provides benefits for Covered Expenses including certain services related to the diagnosis, treatment and correction of any underlying causes of Sexual Dysfunction for all members.

Preventive Care Services

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

The Plan provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams.
- Annual mammogram, Pap test and PSA.
- Items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF), including Nutritional and Genetic Counseling;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease control and Prevention with respect to the Covered Person involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including all FDA-approved contraceptive methods, and lactation counselling and a breast pump for nursing mothers.

Detailed information is available at: www.healthcare.gov

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

Well Baby and Well Child Care

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

Covered Expenses include the following services for an Insured Person:

- Immunizations against (a) diphtheria; (b) Haemophilus influenzae type b; (c) hepatitis B; (d) measles; (e) mumps; (f) pertussis; (g) polio; (h) rubella; (i) tetanus; (j) varicella (chicken pox); (k) rotavirus; and (l) any other children's immunizations required by the State Board of Health. Note: these are not subject to any deductible, copayment, or coinsurance.
- Routine physical examinations.
- Medically appropriate laboratory tests, procedures and radiology services in connection with the examination.
- Routine hearing and vision tests and Physician services in connection with those tests.

Newborn Hearing Benefits

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

Payment will be provided for newborn hearing screenings ordered by the attending physician for an Insured Person as outlined in the Benefits Schedule.

Adult Preventive Care

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

Payment will be provided for Covered Expenses for the following preventive health care services:

- Obstetrical and gynecological services that are provided by qualified Providers for care of or related to the female reproductive system and breasts, and for annual screening, counseling and immunizations for disorders and diseases in accordance with the most current recommendations of the American College of Obstetricians and Gynecologists. Gynecological services include coverage for cervical cancer screening and surveillance tests for ovarian cancer.
- Cervical cancer screening includes examinations and laboratory tests for the early detection of cervical cancer. Examinations and laboratory tests means conventional Pap smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis have been approved by the United States Food and Drug administration. Surveillance tests are for women at risk for ovarian cancer. “At risk for ovarian cancer” means either:
    - having a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
    - testing positive for a hereditary ovarian cancer syndrome.

  “Surveillance tests” mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination

- Charges for mammograms, including: (a) a baseline mammogram (b) a mammogram every other year (c) or a mammogram every year if Medically Necessary and (d) the Physician's interpretation of the laboratory results. Reimbursement for laboratory fees shall only be made if the laboratory meets the mammography accreditation standards established by the North Carolina Medical Care Commission of the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography. Mammograms may be done more frequently if recommended by a Physician because the woman has a personal history of breast cancer or biopsy-proven benign breast disease; a female family member has had breast cancer or the woman has not given birth before the age of 30.
- Prostate Specific Antigen (PSA) tests or equivalent tests for the presence of prostate cancer, and the Office Visit and physical examination associated with this test when ordered by the Insured Person’s Physician or nurse practitioner;
- Charges for colorectal cancer examinations and laboratory tests for cancer for a non-symptomatic insured or for an insured who is: at high risk for colorectal cancer according to the most recently published guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

All Other Routine Services

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

Cigna provides benefits on other types of routine care services for adults besides the services described above. These routine care services or tests do not directly treat an actual Illness, Injury or condition (for example, flu shots, immunizations and lab work).

Genetic Testing

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

This Policy provides benefits for Covered Expenses for charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- an Insured Person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that an Insured Person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

Bone Mass Measurement Test

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

Charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed Medically Necessary. Conditions that would be considered Medically Necessary include, but are not limited to: (1) monitoring Insured's on long-term glucocorticoid therapy of more than 3 months; or (2) a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

Bone Mass Measurement (BMM) means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment.

***A Qualified Person* means one who:**

(a) is estrogen deficient and at clinical risk for osteoporosis or low bone mass;

(b) is experiencing radiographic ostiopenia anywhere in the skeleton;

(c) is receiving long-term glucocorticoid (steroid) therapy;

(d) is having primary hyperparathyroidism;

(e) is being monitored to assess the response to commonly accepted osteoporosis drug therapies;

(f) has a history of low-trauma fractures;

(g) has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.

Organ and Tissue Transplants

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

To be eligible for benefits, organ and tissue transplants must be Prior Authorized by Cigna before services are rendered (see the "Prior Authorization Program").

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

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

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

This Policy provides benefits for reasonable and necessary services related to the search for a donor up a maximum benefit as described in the Benefit Schedule of this Policy.

Cigna has established a network of transplant facilities known as Cigna LIFESOURCE Transplant Network® Facilities (Lifesource Facilities) which consists of transplant programs at participating Hospitals that are designated as a Program of Excellence for meeting superior quality outcomes. These facilities have been established to provide services for specified organ and tissue transplants, including:

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

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

All Transplant services received from Non-Participating Providers are payable at the Out-of-Network level.

Cornea transplants are not available at Cigna LIFESOURCE Transplant Network® Facilities. All other transplant services are covered when received at Cigna LIFESOURCE Transplant Network® Facilities. Transplant services, including cornea, received from non-LIFESOURCE Participating Provider facilities that are specifically contracted for those services are payable at the In-Network level. Transplant services received at Non-Participating Providers are covered at the Out-of-Network benefit level.

The Cigna LIFESOURCE Transplant Network® Facility benefit includes the following travel expense benefits that will be provided for:

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

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

Cigna LIFESOURCE Transplant Network® Facility Benefit Exclusions and Limitations

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

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

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

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

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

- Transportation expenses, lodging and meals when the Cigna LIFESOURCE Transplant Network® Facility is less than 100 miles from the Insured Person's home.
- Charges incurred by more than one travel companion.
- Charges incurred by the Insured Person and a travel companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment Plan.
- Charges in connection with the travel allowance benefit that is not incurred for the treatment Plan at a Cigna LIFESOURCE Transplant Network® Facility, except travel days.
- Charges incurred for transportation for a travel companion other than the trip required to accompany the Insured Person to and from the Facility.
- Charges for the repair or maintenance of a motor vehicle.
- Personal expenses incurred to maintain the Insured Person and a travel companion's residence while the Insured Person and a travel companion are traveling to and from the Facility and during the Insured Person's length of stay. Some examples of these personal expenses include, but may not be limited to: child care costs, house sitting costs, or pet kennel charges.
- Charges for personal comfort or convenience items.
- Charges for Alcohol, drugs or tobacco.
- Reimbursement of any wages lost by the Insured Person and a travel companion for the treatment Plan.
- Travel expenses incurred while receiving treatment at a facility that is not designated as a Cigna LIFESOURCE Transplant Network® Facility.

Hearing Aid Coverage

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

This Policy provides benefits for Covered Expenses for charges made for Medically Necessary hearing aids and related services and supplies ordered by a Physician or audiologist licensed by the state, including but not limited to:

- initial hearing aids and replacement hearing aids,
- a new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual,
- services, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds,
- semi-implantable hearing devices,
- audient bone conductors and Bone Anchored Hearing Aids (BAHAs).

A hearing aid is any device that amplifies sound.

Positional Plagiocephaly

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
Medical Services are covered for the orthotic device to treat the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

Treatment of Diabetes

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

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

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

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

Diagnosis and Treatment of Lymphedema

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

Charges for the diagnosis, evaluation and treatment of lymphedema and are paid on the same basis as any other medical condition. Coverage will include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, which require a prescription and are custom-fit for the Insured, self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

Treatment Received from Foreign Country Providers

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

This Policy provides benefits for Covered Expenses for services and supplies received from Foreign Country Providers for Medical Emergencies and other urgent situations where treatment could not have been reasonably delayed until the Insured Person was able to return to the United States.

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

Telehealth/Telemedicine Medical Services

Services for Telehealth/Telemedicine are covered under this Policy on the same basis as any other medical benefit. Please refer the "Definitions" section of this Policy for a complete description of the services.

Note: this benefit does not include Expanded Access Telehealth Service.

Expanded Access Telehealth Service

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

This Plan provides benefits for electronic visits with an Expanded Access Telehealth Physician. You can initiate a telephone, email or online video visit for treatment of minor acute medical conditions such as a cold, flu, sore throat, rash or headache without referral from Your PCP. You may access Expanded Access Telehealth Physicians by going to www.mycigna.com and click on Find a Doctor, Dentist or Facility; type "Telehealth/Telemedicine/eVisit under 'search criteria

If the Expanded Access Telehealth Physician feels Your condition cannot be optimally treated through remote contact, he or she will refer You to Your PCP for treatment or for referral to another Physician, or advise You to go to urgent care or an emergency room.

The following services are covered:

- Assessment of the condition, including history and current symptoms
- Diagnosis of the condition
- Prescribing medication to treat the condition.
- Providing discharge instructions through email.

You have the option to have records from each Expanded Access Telehealth Physician visit sent to Your regular Physician.

Home Health Care

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

Services must be furnished by a Home Health Agency or a Visiting Nurses Association.

This Policy provides benefits for Covered Expenses for Home Health Care when an Insured Person is confined at home under the active supervision of a Physician. The Physician must be treating the Illness or Injury that necessitates home health care and he or she must renew any order for these services at least once every 30 days. **Home Health services are limited to a combined maximum number of visits each Year as shown in the Benefit Schedule**. If the Insured Person is a minor or an adult who is dependent upon others for nonskilled care custodial services and/or activities of daily living (e.g., bathing, eating, etc.,). Home Health Care will be covered only during times when there is a family member or care giver present in the home to meet the Insured Person's nonskilled care and/or custodial services needs. Covered Services are limited to patient care that is determined to be Medically Necessary. For purposes of this provision a Home Health Care visit is defined as up to 2 hours of Medically Necessary care per visit, with a maximum of 8 visits per day, and prescribed by a Physician in lieu of hospitalization. Home Health Care Services must be provided by one of the following providers:

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

- Services of a medical social worker.

Mastectomy and Related Procedures

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

This Policy provides benefits for Covered Expenses for hospital and professional services under this Policy for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Insured Person was covered under this Policy. If the Insured Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

Breast Reconstruction and Breast Prostheses

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

Coverage includes charges made for reconstructive surgery at any time following a mastectomy, regardless of the length of time elapsed between the mastectomy and reconstruction; benefits include: surgical services to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast; postoperative breast prostheses; mastectomy bras; and external prosthetics. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Post Mastectomy Inpatient Care

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

The decision to discharge a patient from a Hospital following a mastectomy will be made by the attending Physician in consultation with the patient based on the health and medical history of the patient.

Reconstructive Surgery

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
Reconstructive surgery or therapy is covered if it is intended to correct a physical deformity or disfigurement which is accompanied by a functional deficit. Such coverage will not extend to treatment of abnormalities of the jaw, or conditions related to TMJ disorder, unless such treatment is Medically Necessary. Coverage for Medically Necessary treatment of TMJ disorder will include splints and intraoral prosthetic devices for the repositioning of the bones providing that:

- the surgery or therapy restores or improves function;
- reconstruction is required as a result of Medically Necessary,
- surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Congenital Treatment for Newborn Children

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
This Plan provides benefits for Covered Charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your Newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.

Bariatric Surgery

(Please refer to the Benefit Schedule for other benefit provisions which may apply.)
This Plan provides benefits for Covered Charges made for medical and surgical services:

- for the treatment or control of clinically severe (morbid) obesity as indicated below, and
- if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition.

Office Visits for the evaluation and treatment of obesity are limited to a maximum of four (4) visits per Calendar Year. Obesity screening and counseling for adults is recommended by the United States Preventive Services Task Force (USPSTF) as a Body Mass Index (BMI) of 30kg/m or higher to intensive, multicomponent behavioral interventions. For children age 6 years and older the USPSTF recommends that clinicians screen for obesity and offer or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

The following item is specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity;

Treatment for Temporomandibular Joint Dysfunction (TMJ), and Other Disorders Of The Bones and Joints of The Jaw, Face or Head

(Please refer to Your Benefit Schedule for other benefit provisions which may apply.)
Medical services for TMJ and other disorders of the bones and joints of the jaw, face and head are covered on the same basis as any other medical condition. Dental services (i.e. dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this Policy for any diagnosis.

External Prosthetic Appliances and Devices

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

This Policy provides benefits for Covered Expenses made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which is Medically Necessary for the alleviation or correction of Injury, Illness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/prosthetic appliances and devices are defined as artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

The following are specifically **excluded** external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Smoking Cessation

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

This Policy provides benefits for Covered Expenses for Smoking Cessation Attempts, as defined in the Policy up to the maximums shown.in the Benefit Schedule.

Off Label Drugs

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

Charges are covered for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be otherwise approved by the FDA and recognized, with no FDA contraindication, for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: The American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drugs & Biologics Compendium; The Thomson Micromedex DrugDex; the United States Pharmacopeia Drug Information; or any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Clinical Trials

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

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

(1) Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition, and

(2) Either—

(A) the referring health care professional is a participating health care provider and has concluded that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph (1); or

(B) the Insured Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon that person's meeting the conditions described in paragraph (1)

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

The clinical trial must meet one of the following requirements:

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

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

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

For clinical trials, routine patient costs do not include—

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

If one or more in-network providers located in the Insured Person's state of residence are participating in a clinical trial, Cigna may require that the Insured Person participate in the trial through an in-state, in-network participating provider if that provider is willing to accept the Insured Person as a participant in the trial. If the Insured Person is participating in a clinical trial conducted outside of that person's state of residence, this requirement shall not apply.

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

Exclusions And Limitations: What Is Not Covered By This Policy

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed as Covered Expenses** in this Policy.
- Services for **treatment of complications of non-covered procedures** or services.
- Services or supplies that are not **Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**, except as specifically stated in the sections of this Policy titled “Clinical Trials.
- Services **received before the Effective Date of coverage**.
- Services **received after coverage under this Policy ends**.
- Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina **Worker's Compensation** Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Conditions caused by: (a) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (b) an Insured Person **participating in the military service of any country**; (c) an Insured Person **participating in an insurrection, rebellion, or riot** (d) services received as a direct result of an Insured Person’s commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation**
- Any **services provided by a local, state or federal government agency,** except when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- **Any services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- **Court-ordered treatment or hospitalization,** unless such treatment is prescribed by a Physician and listed as covered in this plan.

- Professional **services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from** any of the following:
  - Yourself or Your employer;
  - a person who lives in the Insured Person's home, or that person's employer;
  - a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.
- **Custodial Care**.
- Inpatient or outpatient services of a **private duty nurse**. Except as specifically stated under Home Health Care in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- Inpatient room and board charges **in connection with a Hospital stay primarily for environmental change or physical therapy**; **Custodial Care or rest cures;** services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health.
- Services which are self-directed to a free-standing or Hospital based diagnostic facility.
- Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

  This exclusion does not apply to mammography.
- 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; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; 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.
- Any services 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.
- **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- Services performed by unlicensed practitioners or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
- **Private duty nursing** except when provided as part of the Home Health Care Services or Hospice Services benefits in this Policy.

- Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants, except as specifically provided in this Policy.
- **Routine hearing tests** except as provided in this Policy under Preventive Care and Newborn Hearing Benefits.
- **Genetic screening** or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, expect as specifically stated in this Policy.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance 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, adopted or foster child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- **Aids or devices** that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this Policy.
- **Non-Medical counseling or ancillary services**, including but not limited to education, training, vocational rehabilitation, behavioral training, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays.
- Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty, blepharoplasty regardless of clinical indications.
- 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.

- All services related to any artificial means of conception, including, but not limited to, surgical procedures, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian transfer (GIFT) and associated services.
- **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- The collection and **storage of blood and stem cells** taken from the umbilical cord and placenta for future use in fighting a disease.
- Treatment for **Infertility or reduced fertility** that results from a prior sterilization procedure or a normal physiological change such as menopause.
- All **non-prescription Drugs**, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; **Injectable drugs** ("self-injectable medications) **that do not require Physician supervision; 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, and **Self-administered Injectable Drugs,** and **Self-administered Injectable Drugs,** except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** except as otherwise stated in this Policy. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- Blood administration **for the purpose of general improvement in physical condition.**
- **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices, except for Insureds with the diagnosis of diabetes.
- Medical and surgical services, initial and repeat, intended for the **treatment or control of obesity**, except for treatment of clinically severe (morbid) obesity as shown in the Policy. Medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision are not covered, even when they are related to covered treatment for morbid obesity.
- **Routine physical exams** or tests that do not directly treat an actual illness, injury or condition, including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- **Therapy or treatment intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- **Items which are furnished primarily for personal comfort or convenience** (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Massage therapy.**

- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- **Nutritional counseling or food supplements**, except as stated in this Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings; except for treatment of diabetes, and Consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under 'Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- Any **Drugs,** medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- All **Foreign Country Provider** charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for diopathic short stature, or improved athletic performance is not covered under any circumstances.
- **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet except for Insureds with the diagnosis of diabetes.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician.**
- Charges for **animal to human organ transplants.**
- **Claims received by Cigna after 18 months from the date service was rendered**, except in the event of a legal incapacity.

Pharmacy Payments

For Definitions associated with Prescription Drug benefits, refer to the 'Definitions' section of this Policy.

Covered Expenses

If the Insured Person(s), while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and related Supplies dispensed for a prescription issued to You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When You or Your Family Members are issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the annual medical Deductible and, once the Deductible is satisfied, subject to any applicable Copays and or Coinsurance shown in the Benefit Schedule.

Cigna's Prescription Drug List is available upon request by calling the Customer Service number on Your ID card or on www.myCigna.com.

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

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

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

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

If You redeem a coupon or offer from a pharmaceutical manufacturer for a drug covered under this Policy, Cigna may not allow the dollar amount of the coupon or offer to reduce Your Annual Deductible, Copayment Percentage Copayment and/or Coinsurance. Cigna has the right to determine the amount and duration of any reduction, coupon or financial incentive available for any specific drug covered under this Policy.

Prescription Drugs and Specialty Medication Covered as Medical

When Prescription Drugs and Specialty Medications on Cigna's Prescription Drug List are administered in a healthcare setting by a Physician or health care professional, and are billed with the office or facility charges, they will be covered under the medical benefits of this Policy. However, they may still be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

What Is Covered

- Outpatient Drugs and medications that federal and/or applicable State law restrict the sale by Prescription only, except for Insulin which does not require a prescription.
- Pharmaceuticals to aid smoking cessation in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force.
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Self-Administered Injectable Drugs, and syringes for the self-administration of those Drugs.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.
- Contraceptive Drugs and devices approved by the FDA.
- Specialty Medications.

Conditions of Service

The Drug or medicine must be:

- Prescribed in writing, except for Insulin, by a Physician and dispensed within one year of being prescribed, subject to federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Insured Person's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of an Insured Person's illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through the mail order pharmacy program.
- The Drug or medicine must not be used while the Insured Person is inpatient in any facility.
- **The Prescription must not exceed** the days supply indicated in the "Limitations" section below.
- Infusion and Injectable Specialty Prescription Medications may require prior authorization or pre-certification.

Exclusions

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

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary.
- Drugs available over the counter that do not require a prescription by federal or state law except as otherwise stated in this Policy, or specifically required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Plan and require Prior Authorization. The following are examples of Physician supervised drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of the Policy; except as specifically stated in the sections of this Policy titled “Clinical Trials”, “Clinical Trial Costs” and “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies; except for those pertaining to Diabetic Supplies and Equipment;
- Implantable contraceptive products inserted by the Physician are covered under the Plan’s medical benefits;
- Prescription vitamins (other than prenatal vitamins), dietary supplements, herbal supplements and dietary supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;

- 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 Policy.
- Medications used for travel prophylaxis, except for anti-malarial drugs;
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured's condition. Growth hormone therapy for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
- Drugs obtained outside the United States;
- Any prescription fill or refill of Prescription Drugs and Related Supplies that are lost, stolen, spilled, spoiled or damaged;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Drug convenience kits;
- Prescriptions more than one year from the original date of issue;
- Any costs related to the mailing, sending or delivery of Prescription Drugs;
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Insured Person.

Limitations

Each Prescription order or refill, unless limited by the drug manufacturer's packaging, shall be limited as follows:

- Up to a 90 day supply, at a retail 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
- 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
- Tobacco cessation medications that are 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.
- To a dosage and/or dispensing limit as determined by the P&T Committee.
- You cannot refill a prescription until the 90 day retail, or 90 day mail-order supply has been used, except during a declared state of emergency or disaster.
- 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.

Synchronization of Prescription Refills

Benefits will be provided to allow for the synchronization of Prescription Drugs when it is agreed to by the Member, the Physician, and a Pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the Member for the management or treatment of that chronic illness, provided all of the following apply:

- The Prescription Drugs are covered by the clinical coverage policy;
- The Prescription Drugs are used for treatment and management of chronic conditions, and the medications are subject to refills;
- The Prescription Drugs are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone;
- The Prescription Drugs meet all Prior Authorization criteria specific to the medications at the time of the synchronization request;
- The Prescription Drugs are of a formulation that can be effectively split over required short-fill periods to achieve synchronization; and
- The Prescription Drugs do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

When applicable to permit synchronization this Plan shall apply a prorated daily cost-sharing rate to any medication dispensed by an In-Network Pharmacy. Any dispensing fee shall not be prorated and shall be based on an individual prescription filled or refilled.

Prescription Drug List Exception and Prior Authorization Process

Prior Authorization or Step Therapy is required for certain Prescription Drugs and Related Supplies. Coverage for certain Prescription Drugs and Related Supplies requires the Physician to obtain Prior Authorization from Cigna before prescribing the drugs or supplies. Prior Authorization may include, for example, a Step Therapy determination. Step Therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If Your Physician believes Prescription Drugs or Related Supplies not on Cigna's Drug List are necessary, or wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call, or complete the appropriate Prior Authorization form and fax it to Cigna to request a Prescription Drug List exception or Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician can certify in writing that the Insured Person has previously used a Prescription Drug or Related Supply that is on Cigna's Prescription Drug List or in a Step Therapy Protocol, and the Prescription Drug or Related Supply has been detrimental to the Insured Person’s health or has been ineffective in treating the condition and, in the opinion of the prescribing Physician, is likely to again be detrimental to the Insured Person’s health or ineffective in treating the condition. The Prior Authorization or Prescription Drug List exception will be reviewed and completed by Cigna within 72 hours of receipt. The Physician should make this request before writing the prescription.

An expedited review may be requested by the prescribing Physician when an Insured Person is suffering from a health condition that may seriously jeopardize the Insured Person’s life, health, or ability to regain maximum function or when an Insured Person is undergoing a current course of treatment using a drug not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt. The Physician should make this request before writing the prescription.

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

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

If You disagree with a coverage decision, You may appeal that decision in accordance with the provisions of this Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this Policy entitled "WHEN YOU HAVE A COMPLAINT OR AN APPEAL" which describes the process for the External Independent Review.

If You have questions about specific Prescription Drug List exceptions or a Prior Authorization request, call Customer Service at the toll-free number on the back of Your ID card.

Coverage of New Drugs

All new Food and Drug Administration (FDA)-approved drug products (or new FDA-approved indications) are designated as Non-Prescription Drug List drugs until the Cigna business decision team makes a placement decision on the new drug (or new indication), which decision shall be based in part on the P & T Committee's clinical review of the drug. The business decision team shall make reasonable efforts to make a placement decision for all new FDA-approved drugs (or new indications) within 180 days of the product's release onto the market. Prescription Drug Lists (formularies) are created in conjunction by the P&T Committee and Cigna business decision team.

Reimbursement/Filing a Claim

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

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

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

Claims and Customer Service

Drug claim forms are available upon written request to:

For Retail Pharmacy claims:

Cigna Pharmacy Service Center

P.O. 188053

Chattanooga TN 37422-8053

For mail-order Pharmacy claims:

Cigna Home Delivery Pharmacy

P.O. Box 1019

Horsham PA 19044-1019

1-800-835-3784

Forms are also available online at myCigna.com.

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

Pediatric Vision Benefits for Care Performed by an Ophthalmologist or Optometrist

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

Definitions

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

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

Pediatric Vision Benefits

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

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

What's Covered

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

Examinations – One vision and eye health evaluation by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

Polycarbonate lenses.

Scratch-coating.

Oversize lenses.

Solid and gradient tints.

Ultra-Violet (UV) coating.

Frames – One frame for prescription lenses from Pediatric Frame Collection. Only frames in the Pediatric Frame Collection are covered.

Medically Necessary and Therapeutic Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens Materials as well as the cost of supplemental contact lens professional services including fitting and evaluation.

Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

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

Some Cigna Vision Network Eye Care Professionals may not offer these services. Please check with your eye care professional first before scheduling an appointment.

Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What's Covered" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add on's", 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.

Limitations

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

No payment will be made for expenses incurred for:

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

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

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

Cigna Vision Providers

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

Reimbursement/Filing a Claim

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

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

Cigna Vision
Claims Department
PO Box 385018
Birmingham, AL 35238-5018

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

If You or Your Family Member(s) have any questions about the Pediatric Vision benefit, call the toll-free customer service number on the back of Your ID card.

General Provisions

Medicare Eligibles

Cigna will pay as the Secondary Plan for an Insured Person who is eligible for Medicare as permitted by the Social Security Act of 1965 as amended.

Cigna will estimate the amount Medicare would have paid, and pay as secondary to that estimated amount in the following circumstances:

- An Insured Person who is eligible for Part B of Medicare but is not enrolled

An Insured Person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment Policy. An alternate treatment Policy may include services or supplies otherwise limited or excluded by the Policy. The alternate treatment Policy must be mutually agreed to by Us, the Insured Person, and the Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment Policy in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Policy at any other time or for the Insured Person.

Quality Of Clinical Care Complaints

For complaints concerning the quality of clinical care delivered by your provider, We shall acknowledge the complaint within 10 working days. The acknowledgment shall advise You that: (1) Cigna will refer the complaint to its quality assurance committee for review and consideration or any appropriate action against Your provider and (2) the North Carolina law does not allow for a second-level complaint review for complaints concerning quality of care.

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 is why We have established a process for addressing Your concerns and solving your problems.
Start with Member Services.

We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial or a rescission of coverage, You can call Our toll-free number and explain Your concern to one of Our Customer Service representatives. Please call Us at the Customer Service Toll-Free Number that appears on Your benefit identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

To initiate an appeal, You must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

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

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call Us at the toll-free number on Your benefit identification card, explanation of benefits or claim form.

Most requests for a review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration and who is medical doctor licensed to practice medicine in North Carolina and who was not involved in the prior decision, as determined by Cigna's Physician reviewer. You may present Your situation to the Committee in person or by conference call.

We will acknowledge in writing within 3 working days after We receive Your request and schedule a Committee review. The acknowledgement will include the name, address, and telephone number of the Appeal Coordinator and information on how to submit written material. The acknowledgement will also include a description of Your appeal rights, including the right to: (a) request and receive all information relevant to the review; (b) attend the Committee meeting; (c) present Your case to the Committee and submit supporting materials before and at the Committee meeting; (d) ask questions of any Committee member; and (e) be assisted by a representative of Your choice such as a Physician, family member, or attorney. An attorney representing Cigna may also attend. For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna 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 Cigna, 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.

You and Your Provider will be notified by Cigna in writing, in clear terms, of the Committee's decision within 30 days after We receive Your appeal.

Expedited Appeals

You may request in writing or verbally that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or (b) Your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you believe you are eligible for and request an expedited appeal from Cigna Healthcare, you may be eligible to request an expedited external review from NCDOI. Expedited external review is available if you have a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize your life or health, or jeopardize your ability to regain maximum function. However, you must have also filed a request for an expedited appeal (even if you have not yet received a decision on the appeal) before NCDOI can accept your request for expedited external review.

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 consult with consult with Physician who is licensed to practice medicine in North Carolina, and will respond orally with a decision within 72 hours, followed up in writing within the lesser of two working days or four calendar days. If the expedited review is a concurrent review determination, Cigna will remain liable for health care services until the Insured Person has been notified of the determination.

You may contact the North Carolina Department of Insurance for assistance at:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Fax: 1-919-807-6865
Telephone: 1-919-807-6860
Telephone:1-855-408-1212(Toll-free)
www.ncdoi.com/Smart

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External Review

North Carolina law provides for review of non-certification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to You, arranging for an IRO to review Your case once the NCDOI establishes that Your request is complete and eligible for review. You or someone You have authorized to represent You may request an external review. Cigna will notify You in writing of Your right to request an external review each time You:

- receive a non-certification decision, or
- receive an appeal decision upholding a non-certification decision, or
- Receive a second-level grievance review decision upholding the original non-certification.

In order for Your request to be eligible for external review, the NCDOI must determine the following: (a) Your request is about a Medical Necessity determination that resulted in a non-certification decision; (b) that You had coverage with Cigna in effect when the non-certification decision was issued; (c) the service for which the non-certification was issued appears to be a covered service under Your Plan; and (d) You have exhausted Cigna's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.
The external review process is a voluntary program.

Standard External Review Procedure

For a standard external review, You will be considered to have exhausted Cigna's internal appeal process if You have: (1) completed Cigna's appeal process and received a written determination on the appeal from Cigna, (2) filed an appeal and except to the extent that You have requested or agreed to a delay, have not received Cigna's written decision on appeal within 60 days of the date You can demonstrate that you submitted the request, or (3) received notification that Cigna has agreed to waive the requirement to exhaust Cigna's internal appeal process. If your request for a standard external review is related to a retrospective non-certification decision (a non-certification which occurs after You have received the services in question), You will not be eligible to request a standard review until You have completed Cigna's internal review process and received a written final determination from Cigna.

If You wish to request a standard external review, You (or your representative) must make this request to the NCDOI within 120 days of receiving Cigna's written notice of final determination that the services in question are not approved. When processing Your request for external review, the NCDOI will require You to provide the NCDOI with a written, signed authorization for the release of any of Your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of Your request for a standard external review, the NCDOI will notify You and Your provider of whether Your request is complete and whether it is accepted. If the NCDOI notifies You that Your request is incomplete, You must provide all requested additional information to the NCDOI within 150 days of the date of Cigna's written notice of final determination. If the NCDOI accepts Your request, the acceptance notice will include: (a) the name and contact for the IRO assigned to Your case; (b) a copy of the information about Your case that Cigna has provided to the NCDOI; (c) notice that Cigna will provide You or Your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO.); and (d) notification that You may submit additional written information and supporting documentation relevant to the initial non-certification to the assigned IRO within seven days of the date of the acceptance notice.

If You choose to provide additional any information to the IRO, You must also provide that same information to Cigna at the same time using the same means of communication (e.g., You must fax the information to Cigna if You faxed it to the IRO). When faxing information to Cigna, send it to 1-877-815-4827. If you choose to mail your information, send it to:

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

Please note that You may also provide this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and Cigna. The NCDOI will forward this information to the IRO and Cigna within two working days of receiving Your additional information.

The IRO will send You written notice of the determination within 45 days of the date the NCDOI received Your standard external review request. If the IRO's decision is to reverse the non-certification, Cigna will reverse the non-certification decision within three business days of receiving notice of the IRO's decision and provide coverage for the requested service or supply that was the subject of the non-certification decision. If You are no longer covered by Cigna at the time Cigna receives notice of the IRO's decision to reverse the non-certification, Cigna will only provide coverage for those services or supplies You actually received or would have received prior to dis-enrollment if the service had not been non-certified when first requested.

Expedited External Review Procedure

An expedited external review of a non-certification decision may be available if You have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You meet this requirement, You may make a written request to the NCDOI for an expedited review after You receive a non-certification decision from Cigna AND file a request with Cigna for an expedited appeal or receive an appeal decision upholding a non-certification decision. You may also make a request for an expedited external review if You receive an adverse appeal decision concerning a non-certification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review Your request and determine whether it qualifies for expedited review. You and Your provider will be notified within two days if Your request is accepted for expedited external review. If Your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if Cigna's internal appeal process was already completed, or (2) require the completion of Cigna's internal review process before You make another request for an external review with the NCDOI. An expedited external review is not available for retrospective non-certifications.

The IRO will communicate its decision to You within three days of the date the NCDOI received Your request for an expedited external review. If the IRO's decision is to reverse the non-certification, Cigna will, within one day of receiving notice of the IRO's decision, reverse the non-certification decision for the requested service or supply. If You are no longer covered by Cigna at the time Cigna receives notice of the IRO's decision to reverse the non-certification, Cigna will only provide coverage for those services or supplies You actually received or would have received prior to dis-enrollment if the service had not been non-certified when first requested.

The IRO's external review decision is binding on Cigna and You, except to the extent You may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same Non-certification Decision for which You have already received an external review decision.

External Review Contact

For further information about external review or to request an external review, contact the NCDOI at the following:

By Mail:

NC Department of Insurance

Health Insurance Smart NC

1201 Mail Service Center

Raleigh, NC 27699-1201

Telephone:855-408-1212(Toll-free)

(fax)919-807-6865

In Person:

Health Insurance Smart NC

11 South Boylan Avenue

Raleigh, NC 27603

1-855-408-1212 (Toll-free)

(fax)1-919-807-6860

www.ncdoi.com/Smart for External Review information and Request Form

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the professional qualifications and licensure of the person or persons reviewing the appeal; (2) a statement of the reviewers' understanding of the reason for Your appeal; (3) (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision, including the reviewers' decision in clear terms and the medical rationale in sufficient detail for You to respond further to Cigna's position; (3) reference to the specific Policy provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (6) information about, and contact information for, the Managed Care Patient Assistance Program. A final notice of adverse determination will include a discussion of the decision.

Relevant Information

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

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Terms of the Policy

Entire Contract; Changes: This Policy, including the specification page, endorsements, application, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an Officer of Cigna and attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two Year period.

.**Grace Period:** If You purchased Your Plan from a Marketplace and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided You have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however if We do not receive Your premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions", for further information regarding cancellation and reinstatement.

If You did not purchase Your plan from a Marketplace, or elect to not receive advanced premium tax credit, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see "General Provisions," for further information regarding cancellation and reinstatement.

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

- You fail to pay Your premiums as they become due or by the end of the 31 day grace period for plans not purchased from the marketplace or the 61 day grace period for plans purchased from a Marketplace.
- On the first of the month following Our receipt of Your written notice to cancel.
- When You become ineligible for this coverage. For Eligibility/Ineligibility and Continuation information refer to the section of this Policy titled "Who Is Eligible For Coverage?"
- You have performed, or allowed someone else to perform, an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Policy or coverage.
- When We cease to offer policies of this type to all individuals in your class, North Carolina law requires that we do the following: (1) provide written notice to each Insured Person of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Insured Person on a guaranteed issue basis the option to purchase any other individual hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of an Insured Person.

- When We cease offering all plans in the individual market in North Carolina, We will notify the Commissioner and each Insured Person of the impending discontinuation of Your coverage at least 180 days prior to Your cancellation.
- When the Insured no longer lives, works, resides in the Service Area. This does not apply to a dependent child living outside of the Service Area.
- When Cigna determines that any premium payment for this Policy is being paid directly or indirectly from any source other than You, Your Family Members or an Acceptable Third Party Payor; however, if You, Your Family Members or an Acceptable Third Party Payor make all premium payments for this Policy that are due after the date of Cigna's determination, the Policy shall remain in effect, subject to all other terms and conditions contained herein.

An indirect premium payment is any premium payment made by any person or entity other than the Subscriber, the Subscriber's family members or an Acceptable Third Party Payor as specified in 45 C.F.R. § 156.1250 regardless of whether the actual transfer of money is made from the Subscriber, the Subscriber's family member, or an Acceptable Third Party Payor to Cigna if the funds for that premium payment were provided to the Member by any other person or entity.

Any cancellation shall be without prejudice for any claim for Covered Expense incurred before cancellation.

Certificate of Creditable Coverage
Cigna will supply a certificate of Creditable Coverage when Your or Your dependents' coverage under the Plan ends. It may help you receive credit toward any new pre-existing conditions waiting period that applies on subsequent coverage. You may request a certificate of Creditable Coverage from Customer Service while You are still covered under this Plan and up to 24 months following your termination. You may call Customer Service at the toll-free number listed on Your ID card.

Modification of Coverage: We reserve the right to modify this policy, including Policy provisions, benefits and coverage's, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same Policy form and has been approved by the North Carolina Department of Insurance. We will only modify this Policy for all Insured Persons in the same class and covered under the same Policy form, and not just on an individual basis. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change. We will send written notice and the change will become effective on the next scheduled monthly or quarterly payment premium due date. This Individual Plan is renewable Annually, payment of the premiums will indicate acceptance of the change.

Additional Programs: We may, from time to time offer, or arrange for various entities to offer, discounts, benefits, premium or cost share credits, or other considerations to You for the purpose of promoting Your general health and wellbeing.

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

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

Any premiums accepted in connection with a reinstatement will be applied to a period for which You have not previously paid premium, but not to exceed sixty days prior to the date of reinstatement.

Renewal: This Policy renews on a Calendar Year basis.

Fraud: If the Insured Person has committed, or allowed someone else to commit, any fraud or deception in connection with this Policy, then any and all coverage under this Policy shall be void and of no legal force or effect.

Misstatement of Age: In the event the age of any Insured Person has been misstated in the application for coverage, Cigna shall determine premium rates for that Insured Person according to the correct age and there shall be an equitable adjustment of premium rate within 60 days of discovery so that We will be paid the premium rate appropriate for the true age of the Insured Person.

Legal Actions: You cannot file a lawsuit before 60 days after We have been given written proof of loss. No action can be brought after 3 Years from the time that proof is required to be given.

Conformity With State and Federal Statutes: If any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: if any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

- The Insured Person(s) are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.
- The Effective Date of this Policy is printed on the Cigna identification card and on the Policy specification page.
- Cigna is not responsible for any claim for damages or injuries suffered by the Insured Person while receiving care in any Hospital, Free-Standing Outpatient Surgical Facility, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and providers act as Insured Person(s) contractors.
- Cigna will meet any Notice requirements by mailing the Notice to the Insured Person at the billing address listed in our records. It is the Insured Person's responsibility to notify Us of any address changes. The Insured Person will meet any Notice requirements by mailing the Notice to:

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

- When the amount paid by Cigna exceeds the amount for which We are liable under this Policy, We have the right to recover the overpaid amount from the Insured Person unless prohibited by law.
- In order for an Insured Person to be entitled to benefits under this Policy, coverage under this Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this Policy, an expense is incurred on the date the Insured Person(s) receives a service or supply for which the charge is made.
- We will pay all benefits of this Agreement directly to, Participating Hospitals, Participating Physicians, and all other Participating Providers, whether the Insured Person has Authorized assignment of benefits or not, unless the Insured Person has paid the claim in full in which case we will reimburse the Insured Person.
- In addition, we may pay any covered provider of services directly when the Insured Person assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. However, We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the provider and Our payment to You will be considered fulfillment of Our obligation.
- If We receive a claim from a Foreign Country Provider for a Medical Emergency, any eligible payment will be sent to the Insured Person. The Insured Person is responsible for paying the Foreign Country Provider. These payments fulfill our obligation to the Insured Person for those services.

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

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

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

- Cigna will provide benefits to You or Your Insured Family Member(s) at the Participating Provider level for Covered Services of a terminated Provider for the following special circumstances:
  - Ongoing treatment of an Insured Person up to the 90th day from the date of the provider's termination date.
  - Ongoing treatment of an Insured Person who at the time of termination has been diagnosed with a terminal illness, but in no event beyond 9 months from the date of the provider's termination date.

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

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

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

- If Insured Person(s) were covered by a prior Individual Cigna Policy that is replaced by this Policy with no lapse of coverage:
  - Any waiting period of this Policy will be reduced by the period the Insured Person was covered under the prior Policy, providing the condition, Illness or service was covered under that prior Policy.
  - Benefits used under the prior Policy will be charged against the benefits payable under this Policy.

Other Insurance With This Insurer

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

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

Changing Primary Care Physicians:

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

How to File a Claim for Benefits

Below is an example of what Your cost could be for an In-Network or Out-of-Network medical claim. For the purpose of this example the Deductible has been met. Your actual out-of-pocket responsibility may be different due to Your specific plan and benefits.

Costs with In Network Doctors*		Costs with Out of Network Doctors*	
Billed Charges	$1,000	Billed Charges	$1,000
Cigna's negotiated rate	$650	Amount Cigna Considers Reasonable	$650
You Get a Discount Of	$350	Cigna pays (60% of $650)	$390
Cigna Pays (80% of $650)	$520	You Pay (60% of $650)	$260
You Pay (20% of $650)	$130	Plus Billed Charges Balance ($1000-$650)	$350
Total Amount You Pay	**$130**	**You Pay a Total of**	**$610**

*Assuming any applicable Deductible(s) have been met and any applicable Out-Of-Pocket Maximum has not been met.

Cigna has contracted with Participating Providers to charge only agreed upon Coinsurance, Copayments, or Deductibles for Covered Services. You may not be billed for additional amounts which exceed the amounts agreed upon by Cigna and the Participating Providers. You will be responsible for the difference between the Participating Providers contracted amount with Cigna and amounts that exceed any maximum benefit amounts which are described in the Benefit Schedule of this Policy.

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If Your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on Your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance percentage because actual provider charges may not be used to determine plan and Insured payment obligations.

Notice of Claim: There is no paperwork for claims for services from Participating Providers. You will need to show Your ID card and pay any applicable Copayment; Your Participating Provider will submit a claim to Us for reimbursement. Claims for services from Non-Participating Providers can be submitted by the provider if the provider is able and willing to file on Your behalf. If a Non-Participating Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on Your ID card. Written notice of claim must be given within 18 months after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at the address shown on the first page of this Policy or the address on Your ID card or to any authorized agent of the insurer. Notice should include the name of the Insured, and claimant if other than the Insured, and the Policy identification number.

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

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

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 18 months after the date of the loss, except in the absence of legal capacity. Failure to provide proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

Assignment of Claim Payments:

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

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

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

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

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

Time Payment of Claims:

Benefits will be paid immediately upon receipt of due written proof of loss.

Cigna is entitled to receive from any provider of service information about You which is necessary to administer claims on Your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, You have authorized every provider furnishing care to disclose all facts pertaining to Your care, treatment, and physical condition, upon Our request. You agree to assist in obtaining this information if needed.

Payments of benefits under this Plan neither regulate the amounts charged by providers of medical care nor attempt to evaluate those services. However, the amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.

The Claims Process

- Within 30 days after You receive Covered Services, or as soon as reasonably possible, You or someone on Your behalf, must notify Us in writing of Your claim.
- Within 15 days after We receive Your written notice of an electronic claim or 30 days after We receive Your written notice of a non-electronic claim, We must:
- acknowledge receipt of the claim;
- begin any investigation of the claim;
- specify the information You must provide to file proof of loss. (We can request additional information during the investigation if necessary.); and

- send You any forms We require for filing proof of loss. If We do not send You the forms within this time period, You can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of Your claim. You must give Us this letter within the time period for filing proof of loss. Should Your claim not require the provision of any of the additional information specified above (i.e. the claim is determined to be a "clean claim"), We will pay the claim within 30 days after receipt of a non-electronic claim and 15 days after receipt of an electronic claim.
- Within 180 days after You receive Covered Services, You must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny Your claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person in not legally capable, the required proof must always be given to Us no later than one year from the date otherwise required.
- Within 15 business days after We receive all the information required to secure final proof of loss, We must:
- give You written notice that Your claim or part of Your claim has been accepted and pay benefits within five business days after We notify You of Our acceptance; or
- give You written notice that Your claim has been rejected and tell You the reason(s) for the rejection; or
- give You written notice if We need more time to make Our decision and the reasons We need additional time.

  However, We must notify You of Our final decision within 45 days.

If payment of the claim or part of the claim requires the performance of an act by You, We will pay within five business days after the date You perform the act.

If we fail to comply with the statutory claim payment time requirements set forth above, We will pay the claimant 18 percent interest per year on the claim.

Claim Determination Procedures

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Policy. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a prospective (“pre-service”), concurrent, or retrospective (“post-service”) basis, as described below.

Certain services require prior authorization in order to be covered. The Policy describes who is responsible for obtaining this review. The Insured Person or their authorized representative (typically, their health care provider) must request prior authorization according to the procedures described below, in the Policy, and in the Insured Person’s provider's network participation documents as applicable.

When services or benefits are determined to be not covered, the Insured Person or their representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Policy, in the Insured Person’s provider's network participation documents, and in the determination notices.

Prospective ("Pre-service") and Concurrent Reviews

Prospective and concurrent determinations will be communicated by written or electronic notification to the Insured Person's provider within 3 business days of receiving all necessary information about the admission, procedure, or health care service. Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 3 business days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna's Physician reviewer, will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

In concurrent reviews, Cigna will remain liable for health care services until the Insured Person has been notified of the determination.

Retrospective ("Post-service") Reviews

For retrospective review determinations, Cigna will make the determination within 30 days of receiving all necessary information. Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify the Insured Person or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Insured Person or their representative must provide the specified information to Cigna within 90 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Insured Person or their representative responds to the notice.

The Insured Person or their representative, if applicable, and the Provider will receive written notification of a non-certification within 5 business days after making the non-certification.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination, including clinical rationale, as applicable; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about, and contact information for, the Managed Care Patient Assistance Program; (7) instructions for initiating a voluntary appeal; and (8) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Claim Determination Procedures Under Federal Law (Provisions of the laws of North Carolina may supersede.)

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Policy. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service medical necessity determination." The Policy describes who is responsible for obtaining this review. The Insured Person or their authorized representative (typically, their health care provider) must request Medical Necessity determinations according to the procedures described below, in the Policy, and in the Insured Person's provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, the Insured Person or their representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Policy, in the Insured Person's provider's network participation documents, and in the determination notices.

Pre-service Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Insured Person's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Insured Person's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna's Physician reviewer, will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify the Insured Person or their representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Medical Necessity Determinations

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

Post-service Medical Necessity Determinations

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

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

Post-service Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Premiums

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

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

If You purchased Your Plan from a Marketplace and You have elected to receive Your advanced premium tax credit, Your grace period is extended for three consecutive months provided You have paid at least one full month's premium during the benefit year. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see "General Provisions," for further information regarding cancellation and reinstatement.

If You did not purchase Your plan from a Marketplace, or elect to not receive advanced premium tax credit, there is a grace period of 31 days for the receipt at our office or P.O. Box of any premium due after the first premium. Coverage will continue during the grace period, however, if We do not receive Your premium before the end of the grace period, Your coverage will be terminated as of the last date for which You have paid premiums. Please see "General Provisions," for further information regarding cancellation and reinstatement.

We will refund unearned premium in the event of your Death or if you wish to discontinue coverage.

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

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

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

Cigna also reserves the right to change the premium with 45 days' prior written notice to You. However, We will not modify the premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You and no more frequently than once in any 12 consecutive month period. The change will become effective on the date shown on the notice, and payment of the new premiums will indicate acceptance of the change.

Cigna will not accept the direct or indirect 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 Agreement directly or indirectly 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 Policy.

An indirect premium payment is any premium payment made by any person or entity other than the Subscriber, the Subscriber's family members or an Acceptable Third Party Payor as specified in 45 C.F.R. § 156.1250 regardless of whether the actual transfer of money is made from the Subscriber, the Subscriber's family member, or an Acceptable Third Party Payor to Cigna if the funds for that premium payment were provided to the Member by any other person or entity.

Amendment: NCIND2015CHNGSAMND6-14