Cigna HealthCare of North Carolina, Inc.

INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE

Cigna Connect 6400 Plan

THIS EVIDENCE OF COVERAGE MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ!
This Evidence of Coverage was issued to You by Cigna HealthCare of North Carolina, Inc.(referred to herein as Cigna) based on the information You provided in Your application. If You know of any misstatement in Your application, You should advise Us immediately regarding the incorrect information; otherwise, Your Evidence of Coverage may not be a valid contract.

THIS IS A LEGAL CONTRACT
Read Your Evidence Of Coverage Carefully

Right to Return EOC Within 10 Days Or If You Have Questions
If You are not satisfied, for any reason, with the terms of this EOC 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 EOC will then be null and void. If You wish to correspond with Us for this or any other reason, write:

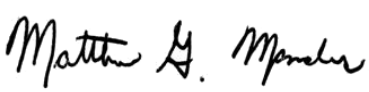
Cigna
Individual Services
P. O. Box 30365
Tampa, FL 33630-3365
1-877-484-5967

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

THIS IS NOT A MEDICARE SUPPLEMENT EVIDENCE OF COVERAGE AND WILL NOT DUPLICATE MEDICARE BENEFITS.

This Evidence Of Coverage 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 Evidence Of Coverage if such benefits exceed the deductible amount shown in the Schedule of Benefits.

Signed for Cigna by:



Matthew G. Manders, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists (OB/GYN)

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 allows 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.

For children, You may designate a pediatrician as the Primary Care Provider.

If You wish to correspond with Us for any 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.

Table of Contents

INTRODUCTION

This Evidence of Coverage (EOC) is a legal contract between You as the Subscriber, and Cigna.

Under this EOC, “We”, “Us”, and “Our” mean Cigna. “You” or “Your” refers to the Subscriber whose application has been accepted by Us under the Agreement issued. When We use the term “Member” in this Agreement, We mean You and any eligible Dependent(s) who are covered under this Agreement.

The benefits of this EOC are provided only for those services that are Medically Necessary as defined in this Agreement EOC and for which the Member 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 EOC or phone Us at the number shown on Your Cigna identification card if You have any questions regarding whether services are covered.

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

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

IF, WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF YOUR PARTICIPATION IN THE EOC, WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED, OMITTED OR THAT YOU OR YOUR DEPENDENT (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 DEPENDENT(S) (EXCLUDING NEWBORN, FOSTER OR, ADOPTED CHILDREN OF THE SUBSCRIBER ADDED WITHIN 61 DAYS AFTER BIRTH OR PLACEMENT IN YOUR HOME), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED, OMITTED OR THAT YOU OR YOUR DEPENDENT(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT (S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE.

IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR EOC LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEEDS TOTAL PREMIUM 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. PLEASE NOTE RESCISSION OF COVERAGE IS SUBJECT TO THE INTERNAL APPEALS PROCESS

RIGHT TO RETURN CONTRACT

If You are not satisfied, for any reason, with the terms of this EOC 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 EOC will then be null and void.

ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

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

Choosing a Primary Care Physician

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

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

If 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.

Cigna will not limit either of the following:

(1) A Participating Provider's ability to discuss with a Member the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.
(2) The Participating Provider's professional obligations to patients as specified under the provider's professional license.

Changing Primary Care Physicians

You may voluntarily change Your PCP but not more than once in any calendar month. We reserve the right to determine the number of times during a Plan Year that You will be allowed to change Your PCP. You may request a change from one Primary Care Physician to another by contacting Us at the Customer Service number on Your ID card. Any such change 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, We will notify You 30 days in advance, for the purpose of selecting a new Primary Care Physician.

If Your PCP Leaves the Network

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

Continuity of Care

If Your PCP ceases to be a Participating Physician, We will notify You. Under certain medical circumstances, We may continue to reimburse Covered Expenses from Your PCP or a specialist You've been seeing at the Participating Provider benefit level even though he or she is no longer affiliated with Cigna's network. If You are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, You may be eligible to receive continuing care from the Non-Participating Provider for a specified time, subject to the treating Provider's agreement. You may also be eligible to receive continuing care if You are in your second or third trimester of pregnancy. In this case, continued care may be extended through Your delivery and include a period of postpartum care.

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.

You may request continuity of care from Cigna after your Participating Provider's termination from Cigna's network; start by calling the toll-free number on your ID card. Continuity of care must be Medically Necessary and approved in advance by Us. Continuity of care will cease upon the earlier of:

- Successfully transition of Your care to a Participating Provider, or
- Completion of Your treatment; or
- The next open enrollment period; or
- The length of time approved for continuity of care ends.

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.

Referrals to Specialists

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

Exceptions to the Referral process:

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in “Covered Services," without a Referral from Your PCP. You do not need a PCP Referral for Virtual visits with a Cigna Telehealth Connection Physician.

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

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

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

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

Standing Referral to Specialist

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

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

We may limit the number of visits and time period for which You may receive a standing Referral. If You receive a standing Referral or any other Referral from Your PCP, that Referral remains in effect even if the PCP leaves the Cigna’s network. If the treating specialist leaves Cigna’s network or You cease to be a covered Member, the standing Referral expires.

Network Exception

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

- Because there is no Participating Provider accessible or available that can provide You timely covered services, or
- For any reason We determine it is in Your best interests to receive care from a non-Participating Provider, then:

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

- Covered Services to which You would have been entitled under this EOC, and
- You will be responsible for only the amount of Non-Participating Provider Covered Expenses that You would have incurred if You received the services from an In-Network Provider..

SCHEDULE OF BENEFITS

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

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

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

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

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

BENEFIT INFORMATION **Note:** **Covered Services are subject to Annual Deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on Cigna Contract Allowance)** **YOU PAY:**
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 dysfunction coverage, cardiac and pulmonary rehabilitation, orthotic device for positional plagiocephaly, organ donor search, sexual dysfunction, sterilization, blood services.	
Annual Deductible **Individual** **Family**	**Deductible** $6,400 $12,800

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Out-of-Pocket Maximum **Individual** **Family**	$7,350 $14,700 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Coinsurance	You and Your Family Members pay 50% of Charges after the Annual Deductible.
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more information in Your Plan. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefits Details".	Your Participating Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance. Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.
Preventive Care Services Please refer to "Preventive Care Services-Periodic Health Examinations" section of the Plan for additional details.	0%, Deductible waived
Newborn/Infant Hearing Screening	0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Pediatric Vision Benefits **See the "Covered Benefits section for details**	
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist through the end of the month in which the member turns 19 years of age. . Please be aware that the Pediatric Vision network is different than the network of your medical benefit**s.**	
, **Comprehensive Eye Exam** *Limited to one exam per year*	0% Deductible waived
Eyeglasses for Children *Limited to one pair per year*	
Pediatric Frames	0% Deductible waived
Single Vision Lenses,	0% Deductible waived
Lined Bifocal Lenses,	0% Deductible waived
Lined Trifocal or Standard Progressive Lenses,	0% Deductible waived
Lenticular Lenses	0% Deductible waived
Contact Lenses for Children *Annual limits apply*	
Elective	0% Deductible waived
Therapeutic	0% Deductible waived
Low Vision Services *Annual limits apply*	0% Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Physician Services **Office Visit** **Primary Care Physician (PCP)** **Specialist Physician (including consultant, referral and second opinion services)** **NOTE:** if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory	$50 Copayment for visits 1 & 2, Deductible waived. 50% for additional visits. 50%
Physician Services, continued **Surgery in Physician's office** **Outpatient Professional Fees for Surgery** (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy) **Inpatient** Surgery, Anesthesia, Radiation Therapy, Chemotherapy **In-hospital visits** **Allergy testing and treatment/injections**	50% 50% 50% 50% 50%
Cigna Telehealth Connection Services ▪ Virtual visit with a **Cigna Connection Physician** Limited to minor acute medical conditions Note: if a Cigna Telehealth Connection Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions. ▪ **Covered Services from any other Participating Physician delivered by Virtual means** (Not limited to minor acute medical conditions)	$40, Deductible waived Same benefit as when service provided in person

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Hospital Services **Inpatient Hospital Services** Facility Charges Professional Charges **Emergency Admissions** Benefits are shown in the Emergency Services Schedule.	50% 50%
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	50%
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services **Facility and interpretation charges** Physician's Office Free-standing/Independent lab or x-ray facility Outpatient hospital lab or x-ray MRIs, MRAs, CAT Scans, PET Scans	50% 50% 50% 50%
Rehabilitative Services Physical, Occupational, Chiropractic Therapy Maximum of 30 visits per Member, per Calendar Year Limits based on Medical Necessity guidelines	50%
Rehabilitative Services **Speech Therapy** Maximum of 30 visits per Member, per Calendar Year Limits based on Medical Necessity guidelines	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Cardiac & Pulmonary Rehabilitation Note: Cardiac Rehabilitation, maximum of 30 visits per Member per Calendar Year. Limits based on Medical Necessity guidelines. Note: Pulmonary Rehabilitation, maximum benefit of 1 course per Member per Calendar Year.	50%
Habilitative Services Maximum of 30 visits per Member per Calendar Year	50%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD), and Other Disorders Related to the Bones or Joints of the Jaw, Face or Head	Copay or Percentage Coinsurance applies for specific benefit provided
Family Planning **Women's Contraceptive Services and Sterilization**	$0, Deductible waived
Male Sterilization	Copay or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery) /Complications of Pregnancy **Initial Office Visit to confirm pregnancy** and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office visit benefit applies
Prenatal services, Postnatal and Delivery (billed as "global" fee)	50%
Hospital Delivery charges	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	50%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Infertility	Copay or Coinsurance applies for specific benefit provided
Sexual Dysfunction	Copay or Coinsurance applies for specific benefit provided
Dialysis **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 50%
Autism Spectrum Disorders **Diagnosis of Autism Spectrum Disorder** Office Visit Diagnostic testing **Treatment of Autism Spectrum Disorder** Please refer to "Autism Spectrum Disorder" section of the Plan for specific details and limitations.	 PCP or Specialist Office visit benefit applies 50% Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Member, per Calendar Year for all facilities listed.	50%
Home Health Services Maximum Unlimited days per Member	50%
External Prosthetic Appliances	50%
Durable Medical Equipment	50%
Orthotic Devices for Positional Plagiocephaly	50%
Hearing Aids Limited to one hearing aid per each hearing-impaired ear every 36 months.	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Diagnosis and Treatment of Lymphedema	50%
Coverage of Clinical Trials	50%
Hospice **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 50%
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness **Inpatient** (Includes Acute and Residential Treatment) **Outpatient** (Includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services **Substance Use Disorder** **Inpatient Detoxification/Rehabilitation** (Includes Acute and Residential Treatment) **Outpatient** (Includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services	 Inpatient Hospital Services benefit applies 50% 50% Inpatient Hospital Services benefit applies 50% 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)	50%
Bariatric Surgery (See benefit detail in the section titled "Covered Services And Benefits" for covered procedures and other benefit limits which may apply.)	50%

BENEFIT INFORMATION Note: Covered Services are subject to Annual Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on Cigna Contract Allowance) YOU PAY:
Organ and Tissue Transplants- (See benefit detail in "Covered Services and Benefits " for covered procedures and other benefit limits which may apply.)	
Cigna LIFESOURCE Transplant Network® Facility	0%
Travel Benefit, (Only available through Cigna Lifesource Transplant Network ® Facility)	
Non-Lifesource Participating Facility specifically contracted to perform Transplant Services	50%
Participating Facility NOT specifically contracted to perform Transplant Services	NOT APPLICABLE
Infusion and Injectable Specialty Prescription Medications and related services or supplies	50%

Emergency Services ***(Note: This Plan covers Emergency Services from In- and Out-of-Network Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Cigna Contract Allowance	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge
Emergency Services – • **Hospital Emergency Room** Coverage includes services no otherwise covered which are required as a direct result of emergency medical treatment, until patient is stabilized	50%	In-network benefit level for an Emergency Medical Condition, otherwise You pay 100%
• **Urgent Care Services**	$75, Deductible waived	In-network benefit level for an Emergency Medical Condition, otherwise You pay 100%
• **Ambulance Services** • **Emergency Transport**	50%	In-network benefit level for an Emergency Medical Condition, otherwise You pay 100%
Emergency transportation to the nearest facility, if such facility is not equipped to provide necessary treatment further transportation is provided. • **Non-Emergency Transport**	Not Covered	Not Covered
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges	50%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then You pay 100%
Professional Services	50%	In-Network benefit level until transferable to an In-Network Hospital; if not transferred then You pay 100%

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	CIGNA HOME DELIVERY PHARMACY YOU PAY
	AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	
In the event that You request a Brand Name drug that has a Generic equivalent, You will be financially responsible for the amount by which the cost of the Brand Name drug exceeds the cost of the Generic drug, plus the Generic Copayment or Percentage Coinsurance shown in the Benefit Schedule.		
Prescription Drug Deductible	Integrated medical and Prescription Drug Deductible	
	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Cigna Mail Order Pharmacy Drug Program** **YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: Preferred Generic	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply
Tier 2: Non-Preferred Generic	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply :	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply
Tier 3: Preferred Brand	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply
Tier 4: Non-Preferred Brand	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply
Tier 5: Specialty	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply.	50% per Prescription or refill, after Deductible Up to a 90 day maximum supply.

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	CIGNA HOME DELIVERY PHARMACY YOU PAY
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)	0%, Deductible waived per Prescription or refill Up to a 90 day maximum supply.	0%, Deductible waived per Prescription or refill Up to a 90 day maximum supply.

DEFINITIONS

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 local, State or Federal government program, including a grantee directed by a government program to make payments on its behalf; 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 publically available criteria and does not in any way consider the health status of any Member 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.

Autism Spectrum Disorders means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified.

Birthing Center means a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The Birthing Center must meet all of the following criteria:

1. Has an organized staff of certified midwives, Physicians, and other trained personnel;
2. Has necessary medical equipment;
3. Has a written agreement to transfer to a hospital if necessary; and
4. Is in compliance with any applicable state or local regulations.

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

Charges means the actual billed Charges; except when the provider has contracted directly or indirectly with Cigna for a different amount

Cigna means Cigna HealthCare of North Carolina, Inc. a health maintenance organization (HMO) which is organized under the laws of the State of North Carolina. Cigna is a party to the EOC.

Cigna LifeSOURCE Transplant Facility is a facility with a transplant program that is included in the Cigna LifeSOURCE Transplant Network®.

Cigna Medical Director means a Physician charged with the direction and management of Cigna Participating Physicians or his designee.

Cigna Telehealth Connection refers to a Covered Service delivered through Virtual means.

Cigna Telehealth Connection Physician refers to a Physician who is part of a designated network from one or more organizations contracted with Cigna to provide Virtual treatment for minor acute medical conditions.

Cigna Telehealth Connection Physician Service means a telehealth visit, initiated by the Member and provided by a Cigna Telehealth Connection Physician, providing Virtual treatment for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Note: the network that provides Cigna Telehealth Connection Physicians is separate from the Plan network, and is only available for services detailed under "Cigna Telehealth Connection" in the "Covered Services and Benefits" section of this Plan.

Coinsurance means the portion of a covered claim (usually a percentage of the total cost) that the Member pays.

Contract Allowance means the rate of payment that has been negotiated with a Participating Provider for Covered Services. When the Participating Provider has contracted with Cigna to receive payment on a basis other than fee-for-service amount, the coinsurance charge will be calculated based on:

- the Contract Allowance for the Covered Services; or
- a Cigna pre-determined fee schedule.

Copayment means a predetermined fee for physician office visits, prescriptions or hospital services that the Member pays at the time of service.

Cosmetic Surgery means surgery that 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.**

Covered Expenses means the expenses incurred for Covered Services under this EOC for which Cigna will consider for payment under this EOC. Additionally, Covered Expenses may be limited by other specific maximums or terms described in this EOC. Covered Expenses are subject to any applicable Deductibles and any applicable benefit limits. An expense is incurred on the date the Member receives the service or supply.

Covered Services are Medically Necessary services or supplies that:

a. are listed in the benefit sections of this EOC, and
b. are not specifically excluded by the EOC, and
c. are provided by a Provider that is:
   (i) licensed in accordance with any applicable Federal and state laws,
   (ii) a Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and
   (iii) acting within the scope of the Provider's license and (if applicable) 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/Custodial Services means any service that is of a sheltering, protective or safeguarding nature. Such services 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 means medical services given primarily to maintain a 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 walking, grooming, bathing, dressing, getting in or out of bed, eating, preparing foods taking medications that can be self-administered); and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Days means calendar days unless expressly stated otherwise.

Deductible means a dollar amount that a Member pays before the plan begins to pay toward the cost of covered medical expenses.

Dependent means those individuals in the Subscriber's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section and are enrolled under the EOC.

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; to include 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 Pharmaceuticals & Supplies include, but are not limited to, blood glucose monitors on Cigna's Prescription Drug List, and test strips for blood glucose monitors; specific blood glucose monitors, visual reading and urine test strips; tablets which test for glucose, ketones and protein; 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.

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.

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 means the date on which coverage under this EOC begins for You and any of Your Dependent(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.

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

Essential Health Benefits means, to the extent covered under this 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.

Evidence of Coverage (EOC) means the Cigna HealthCare of North Carolina, Inc. Individual Plan Evidence of Coverage document, the Summary of Benefits, any Supplemental Riders and any other attachments described herein, the Enrollment Application, and any subsequent amendment or modification to any part of the EOC. Your EOC is also referred to herein as the Plan.

Experimental, Investigational and Unproven Services means medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Cigna Medical Director to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified by the United States Pharmacopoeia Dispensing Information or the American Hospital Formulary Service;
- the subject of review or approval by an Institutional Review Board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase I, II, III or IV Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
- not demonstrated through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this EOC. It is an accumulation of the Individual Deductible paid by each Family Member for Covered Expenses for medical and Prescription Drug Covered Services during a Year. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. Once the Family Deductible amount is satisfied in a year, any remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Schedule of Benefits.

Family means the group of individuals consisting of a Subscriber and his or her Dependents who are enrolled for coverage under this EOC. Family Member refers to any one of these individuals.

Family Out-of-Pocket Maximum: applies if You have a family plan and You or one or more of Your Family Member(s) are insured under this EOC. It is an accumulation of the Deductible, Coinsurance and Copayments each Family Member has accrued during a Year. Each Member can contribute up to his or her Individual Out-of-Pocket amount toward the Family Out of Pocket Maximum. Once the Family Out of Pocket Maximum has been met in a Year, You and Your Family Member(s) will no longer be responsible to pay Coinsurance or Copayments for medical or pharmacy services for Covered Expenses incurred during the remainder of that Year from Participating Providers. Non-compliance penalty charges do not apply to the Family Out of Pocket Maximum and will always be paid by You. The amount of the Family Out-of-Pocket Maximum is described in the Schedule of Benefits section of this EOC

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.

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.

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

- Covered health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (Habilitative Services).
- Services which 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.
- Expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- Individualized and there is a documentation outlining quantifiable, measurable and attainable treatment goals.

Home Health Agencies and Visiting Nurse Associations mean 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; and 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 Participating Hospital, (b) a participating skilled nursing facility or a similar institution, (c) a participating home health care agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, which is a participating Medicare-approved Hospice Care Program.

Hospice Facility means a participating institution or part of it which primarily provides care for Terminally Ill patients; is a Medicare-approved hospice care facility; meets standards established by Cigna; and fulfills all licensing requirements of the state or locality in which it operates.

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.

Hospital Services means, except as limited or excluded by the EOC, services for registered bed patients or outpatients which are customarily provided by acute care hospitals and which are authorized by Cigna as specified in the "Services and Benefits" Section.

Illness is a sickness, disease, or condition of a Member.

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

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

Infertility means the inability after 12 consecutive months of unsuccessful attempts to conceive a child

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.

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

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;
- The median amount negotiated with In-Network (Participating) 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;
- The median amount negotiated with In-Network (Participating) 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.

Medical Services means, except as limited or excluded by the EOC, those professional services of Physicians or Other Participating Health Professionals, including medical, surgical, diagnostic, therapeutic, and preventive services authorized by Cigna as specified in the "Services and Benefits" Section.

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 primarily for the convenience of the Member, the Member's family, Physician or another Provider.
- For Medically Necessary services, nothing in this subsection precludes an insurer from comparing 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.

Member means an individual enrolled under this EOC who is entitled to receive services and benefits hereunder, including the Subscriber and his or her Dependent(s).

Mental Health Services means services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes; these include, but are not limited to: neurosis, psychoneurosis, psychopathy, and psychosis.

Network Dentist means a licensed dentist who has signed an agreement with Cigna Dental to provide general dentistry or specialty care services to You. The term, when used, includes both Network General Dentists and Network Specialty Dentists:

- Network General Dentist means a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide dental care services to you.
- Network Specialty Dentist means a licensed dentist who has signed an agreement with Cigna Dental under which he or she agrees to provide specialized dental care services to You.

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

Non-Participating (Out-of-Network) Pharmacy is a retail Pharmacy with which Cigna has NOT contracted to provide prescription services to Members or a mail-order Pharmacy with which Cigna has NOT contracted to provide mail-order prescription services to Members.

Non-Participating Provider (Out of Network Provider) is a provider who does not have a Participating Provider agreement in effect with Cigna for this Plan at the time services are rendered.

Other Participating (In-Network) Health Care Facility means any facility other than a Participating Hospital or Hospice Facility which is operated by or has an agreement with Cigna to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals, and sub-acute facilities.

Other Participating (In-Network) Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with Cigna to render services to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

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

Participating (In-Network) Hospital means an institution licensed as an acute care hospital under applicable state law, which has an agreement with Cigna to provide Hospital Services to Members.

Participating (In-Network) Pharmacy means a retail pharmacy with which Cigna has contracted to provide prescription services to Members; or a designated mail-order pharmacy with which Cigna has contracted to provide mail-order prescription services to Members.

Participating (In-Network) Physician means a Primary Care Physician (PCP)/Primary Care Provider or other Physician who has an agreement with Cigna to provide Medical Services to Members.

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

Patient Protection and Affordable Care Act of 2010 (PPACA) means 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).

Pharmacy & Therapeutics (P&T) Committee means a committee of Cigna HealthCare 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 means 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 Member resides; and provides services covered by the EOC that are within the scope of his or her licensure.

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.

Premium means the sum of money paid periodically to Cigna by You in order for You and your Dependents to receive the services and benefits covered by the EOC.

Prescription Drug means (i) a drug which has been approved by the Food and Drug Administration for safety and efficacy, (ii) certain drugs approved under the Drug Efficacy Study Implementation review or (iii) 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 means 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 the parameters established by the Pharmacy and Therapeutics (P& T) Committee. The Prescription Drug List is regularly reviewed and updated. You can view the drug list on http://www.cigna.com/ifp-drug-list

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

Prevailing Rate Primary Care Physician means the usual amount which Cigna's Participating Providers charge self-pay patients for services not covered under this EOC

Primary Care Physician/Primary Care Provider, (PCP) means a Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with Cigna, provides basic health services to and arranges specialized services for those Members who select him as their Primary Care Physician (PCP).

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's Medical Director 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 http://www.cigna.com/ifp-drug-list.

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 means 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 EOC, breast reconstruction means reconstruction of a breast incident to mastectomy 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.

Referral The approval You must receive from Your PCP in order for the services of a Participating Provider, other than the PCP, participating Obstetrician/Gynecologist or participating vision care provider to be covered.

Rehabilitative Therapy means, except as limited or excluded by the EOC, treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy and occupational therapy.

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; oral contraceptives (including emergency contraceptive pills); and disposable needles and syringes needed for injecting covered drugs and supplements.

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 Member.

Service Area as is any place where you 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 EOC. For specific information regarding Your Service Area, please check the Provider Directory at www.cigna.com or call the number on the back of your ID card

Skilled Nursing Facility means 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 mental diseases or disorders or custodial or educational care.

Smoking Cessation Attempt means 4 tobacco cessation counseling sessions per attempt of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and one 90-day regimen per attempt of certain Food and Drug Administration (FDA)-approved tobacco cessation medications (including prescription medications and over-the-counter medications with a Physician's prescription; please see the No Cost Preventive Care Drug List on myCigna.com for details).

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

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 EOC.

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 Member is transferred.

Step Therapy is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related supplies, including Specialty Medications. Cigna may also require a Member 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 Member. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.myCigna.com.

Subscriber means an individual who meets the eligibility requirements of the "Subscriber" provision of the "Eligibility" Section and enrolls under the EOC. The Subscriber is a party to the EOC. Also referred to as "You" or "Your".

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Summary of Benefits The part of this EOC that identifies applicable Copayments, Coinsurance, Deductibles, and maximums.

Supplemental Rider means an addendum to this EOC between Subscriber and Cigna.

Telehealth/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 EOC

Terminal Illness/Terminally Ill means an illness of a Member which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.

Urgent Care means medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

Usual and Customary means 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.

Virtual, with respect to Cigna Telehealth Connection, means Covered Services that are delivered via secure telecommunications technologies, including telephones and internet.

We/Us/Our means Cigna HealthCare of North Carolina, Inc.

You, Your, and Yourself means the Subscriber who has applied for, and been accepted for coverage, as a party to this EOC and is named as the Subscriber on the EOC specification page.

ELIGIBILITY

To be eligible for Covered Services You must be enrolled as a Member. To be eligible to enroll as a Member You must meet either the Subscriber or Dependent eligibility criteria listed below.
This EOC is for residents of the state of North Carolina. The Subscriber must notify Us of all changes that may affect any Member's eligibility under this EOC.

Subscriber

To be eligible to enroll as a Subscriber, You must:

- Be 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
- Be a resident of the state of North Carolina; and
- Live within the Service Area of this Plan; and
- Not be incarcerated other than incarceration pending the disposition of charges; and
- Not reside in an Institution; and
- Submit a completed and signed application for coverage and have been accepted in writing by Us.

Dependent

To be eligible to enroll as a Dependent, a person must be:

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.
- **Your own, Your spouse's** or domestic partner's **Newborn children** are automatically covered for the first 31 days of life. 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 60 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 60 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 You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 60 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 You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of placement in the home, and pay any additional premium. 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.

Coverage for a foster child dependent enrolled within 60 days of the placement in the home will be retroactive to the date of the child's placement for foster care.

If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days 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 60 days of the court order date, and paying any additional premium. If no additional premium is required You must enroll the child, but no prior notification is required. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order

Your **stepchildren** who have not yet reached age 26.

Your own, or Your spouse's or domestic partner'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 may require written proof of such disability and dependency within 31 days after the child's 26th birthday.

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 a Subscriber 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 EOC for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period.

Your coverage under this EOC 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 enrolled in a qualified health plan, as defined by PPACA, 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 OFF Marketplace 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 for adoption or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the Subscriber's becoming entitled to Medicare, divorce or legal separation of the covered Subscriber, and death of the covered Subscriber; or
- 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 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).

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.

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage, pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per calendar year), or the qualified individual or dependent is enrolled in any non-calendar year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-calendar year insurance is the last day of the plan or policy year; 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 for adoption, or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee; or
- At the option of the Marketplace, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies;
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- A qualified individual or dependent becomes newly eligible for enrollment in a QHP when they satisfy the Marketplace's citizenship requirement or are released from incarceration;
- 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 enrollee or dependent is determined newly eligible or ineligible for APTC or has a change in eligibility for cost-sharing reductions;
    - A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;
    - A qualified individual who was previously ineligible for APTC because of a household income below 100% FPL and who was also ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, either experiences a change in income or moves to a different state, making them newly eligible for APTC.

  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) and either (1) had minimum essential coverage for one or more days during the 60 days preceding the date of the move, or (2) was living outside of the United States; or
- The qualified individual who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act (or their dependent), may enroll in a qualified health plan or change from one qualified health plan to another one time per month; or

- 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; or A qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator;
- A qualified individual or dependent applies for Marketplace or Medicaid or CHIP coverage during open enrollment or due to a qualifying life event, but is determined ineligible for Medicaid or CHIP after the Exchange open enrollment period has ended or more than 60 days after a qualifying life event;
- The qualified individual or enrollee (or their dependent) adequately demonstrates to the Marketplace that a material error related to plan benefits, Service Area or premium influenced their decision to purchase a QHP; or

- At the option of the Marketplace, the qualified individual provides satisfactory evidence to verify eligibility for an insurance affordability program or enrollment in a QHP following termination of Exchange enrollment due to a failure to verify such status within established time periods, or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify citizenship, status as a national or lawful presence.

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;
- 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, a Member **will become ineligible for coverage** under the EOC:

- When premiums are not paid according to the due dates and grace periods described in the Premium Section.
- For the spouse, when the spouse is no longer married to the Subscriber;
- For You and Your family Member(s) when You no longer meet the requirements listed in the Eligibility section;
- The date the EOC terminates.
- When the Member no longer lives in the Service Area.

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

Continuation

If an Member's eligibility under this EOC would terminate due to the Subscriber's death, divorce or if other Member(s) would become ineligible due to age or no longer qualify as Dependents for coverage under this EOC; except for Your failure to pay premium, the Member's insurance 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 EOC would otherwise terminate. Coverage will continue without evidence of insurability.

Duplicate Enrollment

If a Member is eligible for more than one Cigna membership and is enrolled in more than one Cigna plan at any given time, the Member shall be entitled to only one set of benefits and services and is not entitled to duplicate coverage. Cigna will refund to the Member any Premiums paid by the Member under this EOC for the period of any such duplicate enrollment.

Students Taking a Medically Necessary Leave of Absence

Students taking a Medically Necessary leave of absence are eligible for coverage for up to 12 months, though they will remain eligible for coverage only if they continue to meet all other eligibility requirements. Members age 26 or over who are eligible for coverage because they are students and who take a Medically Necessary leave of absence will remain covered until the earliest of the following dates:

- The date the leave ends;
- The date that is 12 months after the leave began;
- The date that coverage ends for a reason other than the Member's student status (for example, if the student reaches age 27).

Students who return to school after their leave ends are eligible if they meet all eligibility requirements. Documentation of the Medical Necessity for the leave must be submitted at least 30 days before the leave begins, if the absence and the medical reason for the absence are foreseeable. If the absence and the medical reason for the absence are not foreseeable, then documentation of the medical necessity for the leave must be submitted within 30 days after the leave begins.

EFFECTIVE DATE OF COVERAGE

Subject to payment of applicable Premiums in accordance with the "Payments" Section of this EOC and to the other provisions of this EOC, Your coverage will become effective at 12:01 a.m. on the first day of the month following compliance with the eligibility and enrollment requirements of, and acceptance by Cigna. Your Dependent shall have the same effective date as You, unless his or her dependent status is established after such date.

Confined to a Hospital

If You are confined in a hospital on the effective date of Your coverage, You must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When You become a Cigna Member, You agree to permit Cigna to assume direct coordination of Your health care. We reserve the right to transfer You to the care of a Participating Provider and/or Participating Hospital if the Cigna Medical Director, in consultation with Your attending Physician, determines that it is medically safe to do so.

If You are hospitalized on the effective date of coverage and You fail to notify us of this hospitalization, refuse to permit us to coordinate Your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or hospital expenses that are related to Your hospitalization following the first two (2) days after Your coverage begins.

PAYMENTS

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

You must remit the amounts specified by Cigna, to Cigna pursuant to this EOC, for the applicable period of coverage on or before the first day of each such period of coverage. Cigna shall permit a grace period of ten (10) days during which the Premiums may be paid without loss of coverage. If payment is not received within the grace period, the EOC may be terminated by Cigna pursuant to the "Specific Causes of Ineligibility" provision of the "Eligibility" Section. In no event shall Cigna have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Members for whom the payments are actually received by Cigna shall be entitled to health care services hereunder, and then only for the period for which payment is received.

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

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

Cost-Share Reduction Contingency:

If You purchased Your Plan through a federally-facilitated or state-based marketplace and You satisfy certain income thresholds, You may have been eligible for, and Your EOC may include, cost-sharing reductions under federal law. In that case, Your cost-sharing obligation (e.g., copayments, coinsurance or deductible, as applicable) are less than the cost-sharing obligation that would otherwise apply under this EOC.

Any such cost-share reduction is predicated upon payment by the federal government to Cigna of amounts that are intended to reimburse Cigna for the difference between Your cost-sharing obligation and the cost-sharing obligation that would otherwise apply under this EOC. In the event that the federal government fails to make such payments or such payments are otherwise determined to be impermissible or unavailable, Your reduced cost-sharing obligation (e.g., copayments, coinsurance or deductible, as applicable) may, upon 30 days' prior written notice, be increased to the amount that would otherwise apply under this EOC. In such a case, Your cost-sharing obligations will continue to be administered in accordance with applicable federal and state laws and regulations.

In the event that Cigna is prohibited, for any reason, from increasing Your cost sharing obligation in accordance with this section, Your premium may be increased upon ninety (90) days prior written notice to reflect the loss of reimbursement to Cigna.

Cancellation:

We may cancel this Evidence of Coverage only in the event of any of the following:

1. You fail to pay Your premiums as they become due or by the end of the applicable grace period as outlined above.
2. On the first of the month following Our receipt of Your written notice to cancel.
3. When You become ineligible for this coverage.
4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this Plan or coverage.
5. When We cease to offer Plans of this type to all individuals in Your class. In this event, state law requires that we do the following: (1) provide written notice to each Member of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Member 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 a Member.
6. When We cease offering any plans in the individual market in North Carolina, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Subscriber no longer works, lives, or resides in the Service Area. This does not apply to a dependent child living outside of the Service Area.

Unpaid Premium

Upon the payment of a claim under this EOC, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Sufficient notice shall be, during the first year of any EOC, or during the first year following any lapse and reinstatement, a period of 30 days before the premium due date. After one continuous year of coverage and acceptance of premium for any portion of the second or subsequent year sufficient notice shall be a number of full months most nearly equivalent to one fourth the number of months of continuous coverage from the inception date of the EOC, to the date of mailing of the notice: Provided no period of required notice shall exceed two years.

Reinstatement:

If this EOC cancels because You did not pay Your premium within the time granted You for payment, then We may, upon Your request and at Our discretion, agree to reinstate coverage under this EOC.

If this EOC 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 EOC immediately before the due date of the defaulted premium, subject to any amendments or endorsements attached to the reinstated EOC.

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.

Member Payments

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

Premiums are to be paid by You to Us.
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.

An indirect premium payment is any premium payment made by any person or entity other than You, Your 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 You, Your family member, or an Acceptable Third Party Payor to Cigna if the funds for that premium payment were provided to Your or Your Family Member by any other person or entity.

Certificate of Creditable Coverage

If requested, 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.

COVERED SERVICES AND BENEFITS

Members are entitled to receive the Covered Services and benefits set forth in this Section, subject to payment of Copayments, Coinsurance and any applicable Deductible as specified in the Summary of Benefits, and subject to the conditions, limitations and exclusions of this EOC.

AS SET FORTH IN THIS SECTION. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT COVERED EXCEPT AS DESCRIBED IN THE EMERGENCY SERVICES PROVISION OF THE COVERED SERVICES AND BENEFITS SECTION OR WITH THE PRIOR WRITTEN APPROVAL OF THE CIGNA MEDICAL DIRECTOR.

Prior Authorization Requirements

UNLESS PRIOR WRITTEN APPROVAL OF THE CIGNA MEDICAL DIRECTOR IS RECEIVED, SERVICES AND BENEFITS SET FORTH BELOW ARE AVAILABLE ONLY IF MEDICALLY NECESSARY, RENDERED BY PARTICIPATING PROVIDERS, AND EITHER PROVIDED OR AUTHORIZED IN WRITING BY THE MEMBER'S PRIMARY CARE PHYSICIAN.

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

Prior Authorization or Step Therapy is also required for certain Prescription Drugs and Related Supplies. For more information, please refer to "Prescription Drug Benefits" in this EOC

PRIOR WRITTEN AUTHORIZATION IS NOT REQUIRED FOR EMERGENCY SERVICES, OBSTETRICAL AND GYNECOLOGICAL SERVICES, PEDIATRIC VISION AND PEDIATRIC DENTAL SERVICES.

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, preventive care, including well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures. Multiple or bilateral surgical procedures performed by one or more qualified physicians during the same operative session are covered.

Second Surgical Opinion

Following a recommendation for elective surgery, this EOC covers one consultation and related diagnostic service by a physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in your opinion, is not resolved by the first consultation.

Outpatient Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; radiation therapy, chemotherapy and hemodialysis treatment, Spinal manipulation therapy, and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit, and other services which are customarily provided in acute care hospitals. Inpatient Hospital services also include Birthing Center.

Inpatient Services at Other Participating Health Care Facilities

A Member shall be entitled to Inpatient Services at Other Participating Health Care Facilities up to any applicable day maximum shown in the Summary of Benefits when medically appropriate as determined by the Cigna Medical Director. Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids. .

Emergency Services and Urgent Care

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

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

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information Line SM or your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or by Cigna.

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

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

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than one hundred and eighty (180) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through Non-Participating (Out-of-Network) Providers shall be limited to covered services to which you would have been entitled under this EOC, and you will be reimbursed for only the costs that you incur which you would not have incurred if you received the services from a Participating (In Network Provider.

(REMAINDER OF SERVICES ARE LISTED IN ALPHABETICAL ORDER)

Ambulance Service

Ambulance services to the nearest appropriate Provider or facility. Prior authorization for non-emergency ambulance services must be obtained from a Participating Provider that is treating the Member.

Autism Spectrum Disorders

Benefits are provided for:

- diagnosis of Autism Spectrum Disorders; and
- treatment of Autism Spectrum Disorders.

Treatment for Autism Spectrum Disorders includes the following care prescribed, provided, or ordered for an individual diagnosed with an Autism Spectrum Disorder by

1) a Physician licensed to practice medicine in all its branches or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, that are intended to develop, maintain, and restore the functioning of an individual.

Upon request from Cigna, a Provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.

Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, that are intended to develop, maintain, and restore the functioning of an individual.

Bariatric Surgery

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 items are 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..

Bone Mass Measurement Test

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 Members 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 osteopenia 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.

Cigna Telehealth Connection

Cigna Telehealth Connection refers to a Covered Service delivered through Virtual means. There are two components to Cigna Telehealth Connection:

- **Cigna Telehealth Connection Program:** services for the treatment of minor acute medical conditions such as colds, flu, ear aches, are available from a specific set of Providers known as Cigna Telehealth Connection Physicians. You may access Cigna Telehealth Connection Physicians by going to www.mycigna.com and click on Find a Doctor, Dentist or Facility; type "Telehealth/Telemedicine/eVisit under 'search criteria'.

  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 Cigna Telehealth Connection Physicians by going to myCigna.com, then go to Find a Doctor page, then click on Cigna Telehealth Connection.

  If the Cigna Telehealth Connection 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, as appropriate.
  - Providing discharge instructions through email.

  You have the option to have records from each Cigna Telehealth Connection Physician visit for a minor acute medical condition sent to Your regular Physician.

- **Cigna Telehealth Connection other services**, the second component of this benefit, are also available from any Physician who is willing and qualified to deliver appropriate Covered Services through Virtual means. Note: this benefit does not include Cigna Telehealth Connection Physician Service described above.

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

Clinical Trials

Benefits are payable for routine patient services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered 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
    - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
    - the covered person provides medical and scientific information establishing that his participation in such a trial would be appropriate based on the individual 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.

An approved 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 approved for cancer clinical trials by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;
- 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 Services are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna for a covered patient who is not enrolled in a clinical trial, including the following:

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

Routine Patient Services 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; or
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Congenital Treatment for Newborn, Foster and Adoptive Children

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, foster and adoptive child from the moment of birth; and with the treatment of cleft lip or cleft palate.

Dental Care/Confinement/Anesthesia

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

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

With respect to dental confinement/anesthesia, facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, if the confinement has been authorized by Cigna because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a contracted Participating Provider.

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Participating Hospital or Freestanding Outpatient Surgical Facility for:

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

Diabetes Services

Medical services for Diabetes are covered on the same basis as any other medical condition. This Plan 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

Durable Medical Equipment

Purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by Cigna for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided

only when approved as Medically Necessary. The determination to either purchase or rent equipment expected to cost $1,000 or more will be made by the Cigna Medical Director. All maintenance and repairs that result from a Member's misuse are the Member's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Cigna Medical Director.

Note: Durable Medical Equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this EOC. The fact that a Participating Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment.

Family Planning Service

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Foreign Country Providers Services

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

Benefits are subject to all terms, conditions, limitations, penalties, and exclusions of this Plan and will not be more than would be paid if the service or supply had been received in the United States

Habilitative Services

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided. Limits on the number of visits provided under the Rehabilitative benefit do NOT apply to Habilitative Services.

Benefits for services designed to assist You to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame are payable as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for Medically Necessary care and treatment of loss or impairment of speech, stated in the Benefit Schedule.

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 number of visits stated in the Benefit Schedule may be covered if Cigna determines that additional treatment is likely to result in significant improvement by measurably reducing the Member's impairment. Cigna must authorize any such additional visits in advance of treatment being provided.

Hearing Aid Coverage

This EOC 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).

Home Health Services

Home health services when the following criteria are met:

- The Physician must have determined a medical need for home health care and developed a plan of care that is reviewed at thirty day intervals by the Physician.
- The care described in the plan of care must be for intermittent skilled nursing, therapy, or speech services.
- The Member must be homebound unless services are determined to be Medically Necessary.
- The home health agency delivering care must be certified within the state the care is received.
- The care that is being provided is not Custodial Care

Home health services are provided only if the Cigna Medical Director has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or Custodial Services (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a Family Member or care giver present in the home to meet your non-skilled care and/or Custodial Service needs.

Home health services are those skilled health care services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. A visit is defined as a period of 4 hours or less. Home health services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by other participating health care professionals in providing home health services are covered. Home health services do not include services by a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Participating Health Professional. Physical, occupational, and other Rehabilitative Therapy services provided in the home are subject to the benefit limitations described under " Rehabilitative Therapy" in the Summary of Benefits.

Hospice Services

This EOC provides benefits for Covered Expenses for Hospice Care including palliative and supportive medical, nursing and other health services through home or inpatient care for Members who have a Terminal Illness and for the families of those persons, including bereavement counselling for the families for up to 12 months following the death of the terminally ill Member.

Hospice Care Services which are provided under an approved Hospice Care Program when provided to a Member who has been diagnosed by a Participating Physician as having a Terminal Illness with a prognosis of six months or less to live. Hospice Care Services include inpatient care; outpatient services; professional services of a Physician; professional services of a licensed or registered Nurse, services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

- services of a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for curative or life-prolonging procedures;
- services for which any other benefits are payable under the EOC;
- services or supplies that are primarily to aid You or Your Dependent in daily living;
- services for respite (Custodial) care;
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Infertility

This EOC provides benefits for Covered Expenses including certain services related to the diagnosis, treatment and correction of 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.

Internal Prosthetic/Medical Appliances

Coverage for Internal Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for defective body parts. Medically Necessary repair, maintenance, or replacement of a covered appliance is covered.

Laboratory and Diagnostic and Therapeutic Radiology Services

Laboratory services and radiation therapy and other diagnostic and therapeutic radiological procedures.

Lymphedema Diagnosis and Treatment

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 Member, 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.

Mastectomy and Related Procedures

This Plan provides benefits for Covered Expenses for hospital and professional services 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 Member was covered under this Plan. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. 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.

If the Member 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 definition of "Medically Necessary" in this EOC. Benefits will be payable on the same basis as any other Illness or Injury under the Plan.

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.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous abortion (miscarriage) and complications of pregnancy, and maternal risk.

Coverage for a mother and her newly born child shall be available for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

Medical Supplies

Medical supplies include medically appropriate supplies which may be considered disposable, however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aids and gauze are not covered.

Mental Health and Substance Use Disorder Services

Inpatient Mental Health Services
Services that are provided by a Participating Hospital for the treatment and evaluation of mental health during an inpatient admission.

Outpatient Mental Health Services
Services of Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention),outpatient testing and assessment, and medication management when provided in conjunction with a consultation.

Outpatient Substance Use Disorder Rehabilitation Services
Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program.

Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

Inpatient mental health and substance use disorder benefits are exchangeable with partial hospitalization sessions when benefits are provided for not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24) hour period.

Substance Use Disorder Residential Treatment Services
Services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorder conditions. Substance Use Disorder Residential Treatment services are exchanged with Inpatient Substance Use Disorder Rehabilitation services at a rate of two (2) days of Substance Use Disorder Residential Treatment being equal to one (1) day of Inpatient Substance Use Disorder Rehabilitation Treatment.

Substance Use Disorder Residential Treatment Center means an institution which

a. specializes in the treatment of psychological and social disturbances that are the result of Substance use Disorder;
b. provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
c. provides twenty-four (24) hour care, in which a person lives in an open setting; and
d. is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Inpatient Substance Use Disorder Services
Services that are provided by a Participating Hospital for the treatment and evaluation of substance use disorder during an inpatient admission.

Substance Use Disorder Detoxification Services
Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation., Medical Necessity will determine whether such services will be provided in an inpatient or outpatient setting.

Excluded Mental Health and Substance Use Disorder Services
The following mental health and substance use disorder services are specifically excluded from coverage under this Plan:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this EOC;
- Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment (unless associated with chemical or alcohol dependency as described in the Residential Substance Use Disorder Residential Treatment provisions);
- 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; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
- marriage counseling;
- Custodial Care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
- Biofeedback is not covered for reasons other than pain management.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as Medically Necessary.

Ostomy Supplies

Ostomy supplies are supplies which are medically appropriate for care and cleaning of a temporary ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive remover, deodorant, pouch covers, and other supplies as appropriate.

Oxygen

Coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services are not covered outside of the Service Area, except on an emergency basis.

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, where applicable.

Benefits will apply until the end of the month in which the limiting age is reached

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

Covered Benefits
In-Network Covered Benefits for Members, through the end of the month in which the Member turns 19 years of age, include:

- Examinations – One vision and eye health evaluation per year by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Eyeglass lenses include all prescription including prism, choice of polycarbonate, glass or plastic standard single vision, lined bifocal, lined trifocal, lenticular and standard progressive lenses: including these additional lens add-ons:
    - Oversize lenses;
    - All Solid and gradient tints
    - Scratch-coating
    - Ultra-Violet (UV) coating
    - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: anti-reflective coatings; polarized; Hi-Index and lens styles such as Blended Segment, Intermediate, and Premium Progressive lenses.

  * Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

- Frames – One frame for prescription lenses per year from Pediatric Frame Collection. Only frames in the Pediatric frame Collection are covered at 100%. Non-Collection Frames: Member cost share up to 75% of retail.

- Elective 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), including the professional services.
- Therapeutic Contact Lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses. 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 are not covered.

- Low Vision Coverage: Supplemental professional low vision services and aids are covered in full once every twelve (12) months for a Member 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 high-powered spectacles, magnifiers and telescopes, which can aid the Member 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 in excess of the usual and customary charge for the Service or Material
- Charges incurred after the Evidence of Coverage ends or the Insured's coverage under the Evidence of Coverage ends, except as stated in the Evidence of Coverage.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Benefits" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lenses, treatments, "add ons", or lens coatings not otherwise listed in "Covered Benefits." within this section, above.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- 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.
- Services provided out of network without Cigna's prior approval are not covered.

Cigna Vision Providers

To find a Cigna Vision Provider, You should visit **myCigna.com** and use the link on the vision coverage page.

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.

Positional Plagiocephaly

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.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug benefits shown below are subject to all of the terms, conditions and limitations contained in this EOC.

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

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 Copayments and/or Coinsurance shown in the Benefit Schedule.

Services and Benefits

Subject to the provisions of this EOC, Cigna will cover those Medically Necessary Prescription Drugs and Related Supplies, ordered by a Physician and purchased from Participating Pharmacies as designated by Cigna. Cigna will also cover Medically Necessary Prescription Drugs and Related Supplies dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Prescription Drug or Related Supply and a Participating Pharmacy cannot reasonably fill the prescription, such prescription will be covered by Cigna, subject to the provisions of this EOC.

Cigna's Prescription Drug List is available upon request by calling the Member Services number on Your ID card and at www. http://www.cigna.com/ifp-drug-list

Covered Prescription Drugs include, but are not limited to:

- Outpatient Drugs and medications that Federal and/or applicable State law restrict to sale by Prescription only, except for Insulin which does not require a prescription.
- 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; insulin pumps, infusion devices and accessories, oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- Pharmaceuticals to aid smoking cessation in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force.
- 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.

Covered Drugs or medicines 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 Member'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 a Member'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 Member is an 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 precertification

Prescription Drug Benefit Limitations

- Each Prescription Order or refill is limited as follows:Up to a 90 day supply, at a Participating 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 Participating 90 Day 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. Up to a 90-day supply at a mail-order Pharmacy for Preferred Generic, Non-Preferred Generic, Preferred Brand, Non-Preferred Brand and Up to a 90-day supply of Specialty Medications unless limited by the drug manufacturer's packaging; or To a dosage and/or dispensing limit as determined by the P&T Committee.
- Tobacco cessation medications included on Cigna's Prescription Drug List are limited to two 90 day supplies per Year.
- Infusion and Injectable Specialty Prescription Medications may require Prior Authorization.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- **You cannot refill a prescription until the 30-90 day retail, or 90 day mail-order supply has been used, except during a declared state of emergency or disaster.**

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.

Off Label Drugs

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.

Member Payments

Coverage for Prescription Drugs and Related Supplies is subject to a Copayment or Coinsurance. The applicable Copayment or Coinsurance is identified in the Benefit Schedule. In no event will the Copayment or Coinsurance exceed the retail cost of the Prescription Drug or Related Supply.

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

If You redeem a coupon or offer from a pharmaceutical manufacturer for a drug covered under this EOC, **Cigna will not** allow the dollar amount of the coupon, or offer to reduce Your Annual Deductible, Copayment and/or Coinsurance. the amount You pay for the drug, including any applicable Deductible. 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 EOC.

Prescription Drugs and Specialty Medication Covered as Medical

When Prescription Drugs and Specialty Medications on Cigna's Prescription Drug List are administered in a health care 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 EOC. However, they may still be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Authorization, Exception and Appeal Process for Prescription Drugs and Related Supplies

Authorization from Cigna is required for certain Prescription Drugs and Related Supplies, meaning that Your Physician must obtain authorization from Cigna before the Prescription Drug or Related Supply will be covered.

Prior Authorization
When Your Physician prescribes certain Prescription Drugs or Related Supplies, including high cost and Specialty Medications, Cigna requires Your Physician to obtain authorization before the prescription or supply can be filled. To obtain Prior Authorization, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Step Therapy
Step Therapy is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including some higher-cost and Specialty Medications for treatment of conditions including allergies, asthma, diabetes, high cholesterol, mental health and stomach acid reflux. We may require You 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. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com. If Your Physician prescribes a drug for You that is on the Step Therapy list, after You initially fill the Prescription You and Your Physician will receive a letter from Cigna informing You of the Step Therapy Drug You will be required to use when You refill the Prescription. To obtain Step Therapy Authorization, Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Exceptions for Prescription Drugs and Related Supplies not on the Prescription Drug List
If Your Physician prescribes a Prescription Drug or Related Supply that is not on Cigna's Prescription Drug List, he or she can request that Cigna make an exception and agree to cover that drug or supply for Your condition. To obtain an exception for a Prescription Drug or Related Supply Your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

Prescription Drug and Related Supply Authorization and Exception Request Process
To obtain an exception, Your Physician may call Cigna, or complete the appropriate form and fax it to Cigna to request an exception. Your Physician can certify in writing that You have 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 Your health or has been ineffective in treating Your condition and, in the opinion of Your Physician, is likely to again be detrimental to Your health or ineffective in treating the condition. The exception request will be reviewed and completed by Cigna within 72 hours of receipt.

Expedited Review of a Prior Authorization, Step Therapy or Prescription Drug Exception Request
An expedited review may be requested by Your Physician when You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or when You are 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.

If the request is approved, Your Physician will receive confirmation. The Authorization/Exception 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 Authorization will be granted until You no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When Your Physician advises You that coverage for the Prescription Drugs or Related Supplies has been approved, You should contact the Pharmacy to fill the prescription(s).

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

Appeal of a Prior Authorization, Step Therapy or Prescription Drug Exception Denial
If You, a person acting on Your behalf, or the prescribing Physician or other prescriber disagree with a coverage decision, You, a person acting on Your behalf or the prescribing Physician or other prescriber may appeal that decision in accordance with the provisions of this EOC, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this EOC 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, Prior Authorization or a Step Therapy 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 P&T Committee makes a reasonable effort to review all new FDA approved drug products (or new FDA approved indications) within 90 days of its release to the market. The business decision team must make a reasonable effort to review a new FDA approved drug product (or new indications) within 90 days, and make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market, or a clinical justification must be documented if this timeframe is not met.

Reimbursement/Filing a Claim
When a Member purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copay or Deductible shown in the Schedule of Benefits at the time of purchase. The Member does not need to file a claim form.

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

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

1. Any drugs not approved by the Food and Drug Administration.
2. Any drugs that are not on the Prescription Drug List and not otherwise approved as Medically Necessary.
3. Any drugs available over the counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over the counter drug other than insulin, aspirin, or smoking cessation aids, except those required to be covered under the Patient Protection and Affordable Care Act.
4. Any drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
5. Any injectable infertility drugs; except as covered under this Plan, and any injectable drugs are covered under the medical benefits of this EOC and require Prior Authorization. The following are examples of Physician supervised injectable drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
6. Any drugs that are experimental or investigational, within the meaning set forth in the EOC.
7. Any Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized as safe and effective for the treatment of the particular indication in one of the standard reference compendia (drug information for the healthcare provider, The United States Pharmacopoeia Drug Information, or The American Hospital Formulary Service Drug Information) or in medical literature, meaning .scientific studies published in a peer-reviewed national professional medical journal.

8. Any Food and Drug Administration (FDA) approved drug used for purposes other than those approved by the FDA unless the drug, and the Medically Necessary services associated with the administration of the drug, are recognized as safe and effective for the treatment of the Member's specific cancer in at least one standard medical reference compendia or medical literature. Standard medical reference compendia include: The American hospital formulary service drug information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium; Other Authoritative Compendia as identified by the Secretary of the United States Department of Health and Human Services.
9. Any prescription and non-prescription supplies (such as, ostomy supplies), devices, and appliances other than Related Supplies.
10. Any Implantable contraceptive products are covered under the medical benefits of the EOC.
11. Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
12. Any prescription vitamins (other than pre-natal vitamins), dietary supplements, herbal supplements, and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA).
13. Any drugs used for cosmetic purposes that have no medically acceptable use, such as, drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
14. Any drugs used for weight loss, weight management, metabolic syndrome; and antiobesity agents.
15. Any Injectable or infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this EOC.
16. 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", and any benefit language concerning "Off Label Drugs"
17. Any medications used for travel prophylaxis, except for anti-malarial drugs.
18. Any drugs obtained outside of the United States.
19. Any prescription fill or refill of Prescription Drugs and Related Supplies that are lost, stolen, spilled, spoiled or damaged.
20. Any drugs used to enhance athletic performance.
21. Any drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
22. Any prescriptions more than one year from the original date of issue.
23. Any costs related to the mailing, sending or delivery of Prescription Drugs.
24. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Member.

Preventive Care Services – Periodic Health Examinations

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

- Routine physical exams including: guidance and counselling regarding substance use disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counselling.
- Two Smoking Cessation Attempts (maximum of 4 counselling sessions per attempt); Prescription Drugs for Smoking Cessation treatment are covered under the Prescription Drug benefit.
- 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:
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease control and Prevention;
- 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 provided for in the 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, (except for anti-malaria vaccinations), employment, school or sports.

Well Baby and Well Child Care

Covered Expenses include the following services for a Member:

- 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

Payment will be provided for newborn hearing screenings ordered by the attending physician for a Member as outlined in the **Schedule Of Benefits**.

Adult Preventive Care

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 cytology 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 Member’s Physician or nurse practitioner;
- Charges for colorectal cancer examinations and laboratory tests for cancer for a non-symptomatic Member or for a Member 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.

Smoking Cessation

This EOC provides benefits for Covered Expenses for Smoking Cessation Attempts, as defined in the EOC, up to the maximum as shown in the Schedule Of Benefits.

All Other Routine Services

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).

Bone Mass Measurement Test

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 Member'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 osteopenia 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.

Genetic Testing

This EOC 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:

- a Member has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a Member 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 a Member is undergoing approved genetic testing, or if a Member 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 post-genetic testing.

Prosthetics and Orthotics

External Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Basic limb prostheses (artificial arms and legs);
- Terminal devices such as hands or hooks; and
- Speech prostheses.

This Plan provides benefits for Covered Expenses for the initial purchase and fitting of external prosthetic appliances and devices that are ordered by a Participating Physician, available only by

prescription and are necessary for the alleviation or correction of Illness, Injury or congenital defect. Coverage for external prosthetic appliances and devices is limited to the most appropriate and cost effective alternative as determined by the Cigna Medical Director in consultation with the Member's Physician. This includes coverage for repair, maintenance or replacement of a covered prosthetic appliance or device, unless replacement is required because of misuse or loss of the prosthetic on the part of the Member.

The following external prosthetic appliances and devices are specifically excluded from coverage under this Plan:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.
- External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces and splints.
- Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth or as a result of wear and tear.
- Electronic prosthetic limbs or appliances are not covered unless Medically Necessary, when a less-costly alternative is not sufficient.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  a. Rigid and semi-rigid custom fabricated orthoses;
  b. Semi-rigid pre-fabricated and flexible orthoses; and
  c. Rigid pre-fabricated orthoses, including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthotics – custom foot orthoses are only covered as follows:
  a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  b. When the foot orthosis is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
  c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
  d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

The following orthoses & orthotic devices are specifically excluded from coverage under this Plan, unless provided in the Diabetic Services and Supplies Section:

- Prefabricated foot orthoses;

- Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded from coverage under this Plan:

- Copes scoliosis braces.

Splints

A splint is defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the Member will not be covered; and
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- a. No more than once every 24 months for Members 19 years of age and older;
- b. No more than once every 12 months for Members 18 years of age and under; and
- c. Replacement due to a surgical alteration or revision of the site.

The following external prosthetic appliances and devices are specifically excluded from coverage under this Plan:

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

Reconstructive Surgery

Reconstructive surgery or therapy that constitutes necessary care and treatment for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption who were covered from birth, adoption or adoption placement. Additionally, reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or
- reconstruction is required as a result of Medically Necessary, non-cosmetic 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.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Cigna Medical Director.

Services for Pulmonary and Cardiac Rehabilitation

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

- 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 is 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.

Services for Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Chiropractic Therapy and Speech Therapy)

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.

Benefits for the therapeutic use of heat, cold, exercise, electricity, ultraviolet light, or massage to improve circulation, strengthen muscles, encourage return of motion, or for treatment of Illness or Injury; and the conservative management of acute neuro-musculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function are payable up to the maximum number of visits as stated in the Benefit Schedule.

Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech, payable up to the number of visits as stated in the Benefit Schedule. 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.

To be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or illness. Services are not covered when they are considered custodial, training, educational or developmental in nature. Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an Illness or Injury. Note: this provision does not apply to services for Habilitative Therapy.

Special Note:

Additional visits for Physical and 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 Member's impairment; and
- Cigna authorizes this in advance.

The following services are specifically excluded from coverage under the Rehabilitative Services benefit:

- Services of a Provider which are not within his or her scope of practice, as defined by state law;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent reoccurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

Sexual Dysfunction Services

This Plan provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of Sexual Dysfunction for all Members.

Treatment for Temporomandibular Joint Dysfunction (TMJ), and other disorders of the bones and joints of the jaw, face or head

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.

Transplant Services

Coverage is provided for human organ and tissue transplant services at designated facilities throughout the United States. Coverage is also provided for human organ and tissue transplant services at other Cigna Participating (In-Network) facilities contracted with Cigna for transplant services. Transplant services include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own program.
- If You are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this plan will be provided for both You and the donor. In this case, payments made for the donor will be charged against Your benefits.
- If You are the donor for the transplant and no coverage is available to You from any other source, the benefits under this plan will be provided for You. However, no benefits will be provided for the recipient.

Coverage will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant surgery. Transplant services include medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney,

kidney/pancreas, kidney/liver, liver, lung, pancreas or intestinal, including small bowel, small bowel/liver or multivisceral.

- The evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.
- The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at a designated Cigna LIFESOURCE Transplant Network® facility

Reimbursement may not be denied for an otherwise Covered Expense incurred for any organ transplant procedure solely on the basis that such procedure is deemed Experimental or Investigational, unless supported by the determination of the Office of Health Care Technology Assessment, within the Agency for Health Care Policy and Research, within the federal Department of Health and Human Services, that such procedure is either Experimental or Investigational, or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.

Transplant services received at Participating (In-Network) Provider facilities specifically contracted with Cigna for those Transplant services are payable at the In-Network level.

NOTE: Some In-Network Provider facilities are NOT contracted with Cigna to provide transplant services. If You elect to have transplant services at an In-Network facility that is not contracted with Cigna to provide transplant services, those services would be covered at the Plan's Out-of-Network benefit level. For more information on whether an In-Network facility is contracted with Cigna to provide transplant services, contact Your Cigna case manager or call the number on Your ID card.

Transplant services received at any other facilities, including Non-Participating (Out-of-Network) Providers and Participating (In-Network) Providers not specifically contracted with Cigna for Transplant services, are not covered.

Transplant Travel Services

Coverage is provided for transportation and lodging expenses incurred by You in connection with a pre-approved organ/tissue transplant that if reimbursed by Cigna would be characterized by the Internal Revenue Service as non-taxable income pursuant to Publication 502, and subject to the following conditions and limitations. Benefits for transportation and lodging are available to You only if You are the recipient of a pre-approved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term "recipient" includes a Member receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include Charges for:

- transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and
- lodging while at, or traveling to and from the transplant site.

Travel and lodging expenses for organ and tissue transplants and charges related to a search for a donor may be reimbursed based on Cigna guidelines that are available upon request from a transplant coordinator. Call the Customer Service number on the back of your ID card to assure coverage of these services.

In addition to You being covered for the Covered Services associated with the items above, such Covered Services will also be considered covered travel expenses for one companion to accompany You. The term "companion" includes Your spouse, a member of Your family, Your legal guardian, or any person not related to You, but actively involved as Your caregiver who is at least eighteen (18) years of age.

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within less than sixty (60) miles of Your home;
- food and meals;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for airline transportation that exceed coach class rates.

Note: Transplant travel benefits are not available for corneal transplants.

Transplant Travel Services are only available when the Member is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available where the Member is a donor.

BENEFIT EXCLUSIONS AND LIMITATIONS

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

Benefit Exclusions

In addition, the following are specifically excluded Services:

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

surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.

12. The following services are excluded from coverage regardless of clinical indications;
    - Macromastia or Gynecomastia Surgeries;
    - Surgical treatment of varicose veins;
    - Abdominoplasty;
    - Panniculectomy;
    - Rhinoplasty;
    - Blepharoplasty;
    - Redundant skin surgery;
    - Removal of skin tags;
    - Acupressure;
    - Craniosacral/cranial therapy;
    - Dance therapy, movement therapy;
    - Applied kinesiology;
    - Rolfing;
    - Prolotherapy; and
    - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
13. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, Charges made for services or supplies provided for or in connection with a fractured jaw, or an accidental injury to sound natural teeth are covered, where the continuous course of treatment is started within six (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch, except for pediatric dental services.
14. Any medical and surgical services for the treatment or control of obesity that are not included under the “Services and Benefits” section of this EOC.
15. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
16. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Services and Benefits."
17. All services related to In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
18. Reversal of male and female voluntary sterilization procedures.

19. 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.
20. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the EOC.
21. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation, except as specifically stated in this EOC.
22. All services related to **Applied Behavioral Therapy treatment,** including but not limited to: the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior
23. Education services except for Diabetes Self-Management Training Program, treatment for Autism, or as specifically provided or arranged by Cigna.
24. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected, except as specifically stated in this EOC.
25. Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnotism; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under “Rehabilitative Therapy” and “Habilitative Therapy” are not subject to this exclusion.
26. Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that do not consist exclusively of Covered Services
27. Educational services except for Diabetes Self-Management Training; treatment for Autism, counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.
28. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", Diabetic Services”, or “Breast Reconstruction and Breast Prostheses” sections of the “Services and Benefits” section. Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home

Health Services" provisions, Durable Medical Equipment items that are not covered, include but are not limited to those listed below:

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

29. Private hospital rooms and/or private duty nursing except as provided in the “Home Health Services” or “Hospice Services” section of “Services and Benefits.”, or when deemed medically appropriate. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.
30. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of Illness or Injury.
31. Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
32. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in “Services and Benefits” section of the EOC.
33. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
34. Eyeglass lenses and frames and contact lenses; except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery, or those covered under Pediatric Vision benefit.
35. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
36. Treatment by acupuncture.
37. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Services and Benefits.”

38. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
39. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
40. Genetic screening; except for testing for the occurrence of BRCA gene (breast cancer related genetic marker) under federal preventative care for women, or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
41. Dental implants for any condition, except as otherwise stated in this EOC.
42. Charges for the collection or obtaining of blood or blood products from a blood donor, including the Member in the case of autologous blood donation.
43. Blood administration for the purpose of general improvement in physical condition.
44. Cost of biologicals that is immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
45. Cosmetics, dietary supplements and health and beauty aids.
46. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
47. All vitamins and medications and contraceptives available without a prescription ("over-the-counter") except for those covered under mandate of the 2010 Patient Protection and Affordable Care Act (PPACA).
48. 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.
49. 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) a Member participating in the military service of any country; (c) a Member participating in an insurrection, rebellion, or riot (d) services received as a direct result of a Member commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Member being engaged in an illegal occupation;
50. Massage therapy.
51. The following mental health and substance use disorder services are specifically excluded from coverage under this Plan:
    - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this EOC;
    - Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment (unless associated with chemical or alcohol dependency as described in the Residential Substance Use Disorder Residential Treatment provisions);
- 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; music therapy; meditation; visualization; acupuncture; acupressure, reflexology, light therapy, aromatherapy, energy-balancing; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf.
- marriage counseling;
- Custodial Care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
- Biofeedback is not covered for reasons other than pain management.

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

Benefit Limitations

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

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.

Note: A valid grievance does not include the denial of a service specifically excluded by this Plan.

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 HealthCare of North Carolina, Inc.
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, 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 a 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 Member 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
Telephone: 1-919-807-6860
Telephone: 1-855-408-1212(Toll-free)
www.ncdoi.com/Smart

.

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 HealthCare of North Carolina, Inc.
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)

In Person:

Health Insurance Smart NC
11 South Boylan Avenue
Raleigh, NC 27603
1-855-408-1212 (Toll-free)
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 EOC 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 was (a) 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 EOC or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

RELATION OF THE EOC TO OTHER SOURCES OF PAYMENT FOR HEALTH SERVICES

Workers' Compensation

Benefits under this EOC should not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event Cigna renders or pays for health services which are covered by a workers' compensation plan, Cigna shall have a right to receive reimbursement either (1) directly from the entity which provides Member's workers' compensation coverage; or (2) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where Cigna has directly rendered or arranged for the rendering of services, Cigna shall have the right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where Cigna does not render services but pays for those services which are within the scope of the "Services and Benefits" Section of the EOC, Cigna shall have a right of reimbursement to the extent that Cigna has made payments for the care and treatment so rendered.

Recovery of Excess Benefits

In the event a service or benefit is provided by Cigna which is not required by this EOC, that service or benefit shall be considered an excess benefit. The payment or provision of an excess benefit may occur due to a claim overpayment or the provision of services to non-Members. Cigna shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from any person or entity to, or for, or with respect to whom, such services were provided or such payments were made. This right of recovery shall be Cigna's alone and at its sole discretion. If determined necessary by Cigna, the Member (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to Cigna such instruments and papers required and do whatever else is necessary to secure Cigna's rights hereunder.

Other Insurance With This Insurer

Insurance effective at any one time on the Subscriber under a like Cigna EOC or policies is limited to the one such EOC elected by the Subscriber, or the Subscriber's beneficiary or estate, as the case may be, and Cigna will return all premiums paid for all other such policies, less the amount of any claims paid under those policies or EOCs.

Insurance With Other Insurers

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this EOC shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this EOC) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

Medicare Eligibles

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

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 to enroll in Part B of Medicare, but is not enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him. This reduction will not apply to any Insured Person except as listed under "Cigna will pay as the Secondary Plan…"above

Right to Receive and Release Information

We, without consent of or notice to You, may release to or obtain from any person or organization or governmental entity any information with respect to the administration of this Section. You shall provide Cigna any information it requests to implement this provision. We, without consent of or notice to You, may obtain information from and release information to any plan with respect to You in order to coordinate Your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate Your benefits pursuant to this section.

AMENDMENT OR MODIFICATION OF EOC

Amendment or Modification by Consent of the Parties

The EOC may be amended or modified at any time by Cigna with prior notification as indicated below. Cigna Amendments are effective as of the date indicated in the Amendment.

Amendment or Modification by Notice from Cigna

Cigna may amend or modify the provisions of this EOC, including any Premiums and Copayments, by giving at least thirty 30days prior written notice to the Subscriber.

Uniform Modification of Coverage

The provisions of this EOC may be modified to reflect product revisions which have uniformly been made to this Individual and Family Plan. Cigna reserves the right to modify this EOC, including EOC provisions, benefits and coverages, 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 EOC form. We will only modify this EOC for all Members in the same class and covered under the same EOC form, and not just on an individual basis.

Cigna 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.

Amendment or Modification by Law or Regulation

The provisions of the EOC are subject to the approval of all regulatory bodies and in the event that regulatory bodies request any amendment or modification of the EOC, such amendment or modification shall supersede the provisions of the EOC. Furthermore, any state or federal laws or regulations enacted or promulgated which are in conflict with the provisions of the EOC shall be deemed modifications of the EOC on the date such enactment or promulgation is applicable to this EOC.

MISCELLANEOUS

Additional Programs

Cigna may from time to time offer, or arrange for various entities to offer, discounts or other consideration to MEMBERS for the purpose of promoting the general health and well-being of Members. Contact Cigna Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs, which do not constitute benefits under this EOC, may include discounts on the following types of services:

- Health Club/Gym Memberships
- Tai Chi Classes
- Weight Loss Programs
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes - Selected classes may be offered to Our Members for a copayment at participating Cigna Health Care Centers.
- Cigna HealthCare Healthy Babies Program®

These programs are provided for the benefit of Cigna HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty (60) days' prior notice.

Relationships

The Subscriber enters into the EOC on behalf of the eligible individuals enrolling under the EOC. Acceptance of the EOC by the Subscriber is acceptance by and binding upon those who enroll as Subscribers and Dependents.

The relationship between Cigna and Participating Providers who are not employees of Cigna are independent contractor relationships. Such physicians, hospitals, and providers are not agents or employees of Cigna; and Cigna and its employees are not agents or employees of such physicians, hospitals or providers.

Notice

With respect to this EOC Cigna, means written notice which shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed to the latest address furnished to Cigna by Subscriber or by the Member.

Entire EOC Changes;

This EOC, and the attached papers, if any, constitutes the entire contract of insurance between the parties. The EOC supersedes any other prior EOCs between the parties. No agent or other person, except an officer of Cigna, has authority to waive any conditions or restrictions of the EOC; extend the time for making payment; or bind Cigna by making any promise or representation, or by giving or receiving any information, except as otherwise provided under applicable law. No change in the EOC shall be valid unless stated in an Amendment attached hereto signed by an officer of Cigna.

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

After this EOC has been in force for a period of two years during the lifetime of the Member (excluding any period during which the Member is disabled), it shall become incontestable as to the statements contained in the application.

Severability

If any term, provision, covenant or condition of the EOC is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

No Implied Waiver

Failure by Cigna on one or more occasions to avail itself of a right conferred by the EOC shall in no event be construed as a waiver of Cigna's right to enforce said right in the future.

Records

Cigna keeps records of all Members, but shall not be liable for any obligation dependent upon information from the Subscriber prior to its receipt in a form satisfactory to Cigna. Incorrect information furnished by the Subscriber may be corrected, if Cigna shall not have acted to its prejudice by relying on it. All records of the Subscriber and Cigna which have a bearing on coverage of Members hereunder shall be open for review by Members at any reasonable time.

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

Clerical Error

No clerical error on the part of Cigna shall operate to defeat any of the rights, privileges or benefits of any Member.

Misstatement of Age

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

Administrative Policies Relating to This EOC

Cigna may adopt reasonable policies, procedures, rules and interpretations which promote orderly administration of this EOC. With respect to Covered Services under this EOC, Cigna applies these guidelines:
The most appropriate procedure, supply, equipment or service which can be safely provided, rendered in the least intensive setting that is appropriate for the delivery of the services and supplies; where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting, and that satisfies the following requirements:

i) Must have been proven by scientific studies published in peer-reviewed medical literature to be associated with beneficial health outcomes, demonstrating that the expected health benefits are clinically significant and produce a greater likelihood of benefits, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and

ii) Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

iii) For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Conformity With State and Federal Statutes: If any provision of this EOC 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.

Access to Information Relating to Provider Services

Cigna is entitled to receive from any Provider who renders service to a Member all information reasonably necessary to fulfill the terms of this EOC. Subject to applicable confidentiality requirements, Members hereby authorize any provider rendering service hereunder to disclose all facts pertaining to such care and treatment; also, to render reports pertaining to such care or physical condition and permit copying of records by Cigna.

EOC Binding on Members

By electing health care coverage pursuant to this EOC, or accepting services or benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions herein. However, this EOC shall be subject to amendment, modification or termination in accordance with any provisions hereof, without the consent or concurrence of the Members.

Applications, Statements, etc.

Members or applicants for membership shall complete and submit to Cigna such applications or other forms or statements as Cigna may reasonably request. Members warrant that all information shown in such applications, forms or statements shall be true, correct and complete. All rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete.

Successors and Assigns

This EOC shall be binding upon and shall inure to the benefit of the Successors and Assigns of Cigna, but shall not be assignable by any Member.

Identification Card

Cards issued by Cigna to Members pursuant to this EOC are for identification only. Possession confers no right to services or other benefits under this EOC. To be entitled to such services or benefits the holder must, in fact, be a Member on whose behalf all Charges and Member payments under this EOC have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the terms of this EOC, or who permits another person to receive such services or benefits, shall be chargeable therefor at Prevailing Rates. If any Member permits the use of his or her Cigna identification card by any other person, such card may be retained by Cigna, and all rights of such Member hereunder may be terminated according to the “Specific Causes for Ineligibility” Section.