Cigna HealthCare of Illinois, Inc.

INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE

Cigna Connect 3400

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 Illinois, Inc. 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.

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 EOC 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 EOC 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.

Right to Return Contract

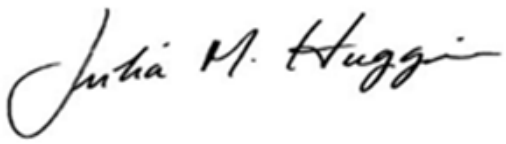
If You are not satisfied, for any reason, with the terms of this EOC You may return it to Us within 10 days of receipt. We will then cancel Your coverage as of the original Effective Date and promptly refund any Premium You have paid. This EOC will then be null and void from the beginning. However, if services are rendered or claims are paid for the enrollee or dependent by the HMO during the 10 day examination period, the enrollee shall not be permitted to return the contract and receive a refund of the Premium paid. If the Annual Open Enrollment Period or special enrollment period has expired at the time the EOC is returned, You must wait until the next Annual Open Enrollment Period or special enrollment period to enroll in a plan.

If You wish to correspond with Us for any reason, write:

Cigna
Individual Services
PO Box 182223
Chattanooga TN 37422

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

Signed for Cigna by:



Julia M. Huggins, President

Anna Krishtul, Corporate Secretary

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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 EOC issued. When We use the term “Member” in this EOC, We mean You and any eligible Dependent(s) who are covered under this EOC.

The benefits of this EOC are provided only for those services that are Medically Necessary as defined in this 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 CHILDREN OF THE MEMBER ADDED WITHIN 60 DAYS AFTER BIRTH), 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.**

While You are covered under this EOC, Cigna will not impose eligibility rules or variations in premium based on your health status, medical condition, claim experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. We will not discriminate against You for coverage under this EOC on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this EOC that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

SERVICE AREA RESTRICTIONS

This EOC includes a Service Area restriction which requires that all Members receive services in the defined service area. Coverage outside of the defined Service Area is limited to Emergency Services and Emergency Medical Condition only.

ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

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

Choosing a Primary Care Physician

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

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

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 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 Network Specialist ceases to be a Participating Physician, We will notify You in writing of his or her impending termination at least 60 days in advance of the date the PCP leaves the network and provide assistance in selecting a new PCP or identifying a new Network Specialist to continue providing Covered Services. If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that Provider.

Referrals to Specialists

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

Exceptions to the Referral process:

If You are a female Member, You may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in “Covered Services and Benefits," 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.

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

Standing Referral to Specialist

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

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

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

Continuity of Care for a Transition Period

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

1. Of 90 days from the date of the notice from Cigna that Your Physician's termination as a Network Provider if You are in an ongoing course of treatment; or
2. If You have entered the third trimester of pregnancy at the time You receive notification of Your Physician's termination as a Network Provider, You can receive transition care from that Physician through delivery and post-partum care related to the delivery.
3. In either instance above, Your Physician must agree to:
   a) Continue to accept reimbursement from Cigna at the rates applicable prior to the start of the transitional period; and
   b) Adhere to Cigna's quality assurance requirements and provide the necessary medical information related to the transitional care; and
   c) Otherwise adhere to Cigna's policies and procedures, including but not limited to procedures regarding Referrals and obtaining pre-authorizations for treatment.
4. You must request transitional services in writing within 30 days from Your receipt of notification that Your PCP or specialist Physician has terminated as a Network Provider. Within 15 days of Your request, Cigna will notify You if Your request for transitional services was denied because Your Physician did not agree to one or more of the conditions listed under #3 above. This notification will be in writing and will include the specific reasons for the denial.

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

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

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

Special Circumstances

This EOC does not cover expenses incurred for services provided by Non-Participating Providers except in the limited situations described below. Your cost-sharing for Covered Expenses incurred for the services of a Non-Participating Provider in these special circumstances is indicated in the Benefit Schedule.

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. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider. We will provide You with an explanation of benefits and request that You notify Us if the Non-Participating Provider bills You for amounts beyond the amount paid by Us. We will then resolve any amounts the Non-Participating Provider bills You beyond the amount paid by Us, consistent with You being held harmless for any amounts beyond what You would have paid for the same services from a Participating Provider.

- **Emergency Services**
  Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital are covered as described in the benefits Schedule. Any expenses incurred for services of a Non-Participating Provider after the patient is Stabilized and his/her condition permits transfer to a Participating Hospital and/or to the care of a Participating Physician are not covered.

- **Other Circumstances**
  Covered Expenses for non-Emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the Benefit Schedule in the following cases:
  - when You have a Referral from Your Participating (PCP) to a Non-Participating Provider; or
  - when those services are unavailable from a Participating Provider, or
  - for any other reason We determine it is in Your best interests to receive services from a Non-Participating Provider.

  For all situations listed above, You must obtain Prior Authorization before receiving care from a Non-Participating Provider.

DEFINITIONS

90 Day Retail Pharmacy means a Participating retail Pharmacy that has an agreement with Cigna, or with an organization contracting on Cigna's behalf, to provide specific Prescription Drugs and Related Supplies, including, but not limited to: extended days' supply, Specialty Medications and customer support services. Please note: not every Participating Pharmacy is a 90 Day Retail Pharmacy, however every Participating Pharmacy can provide a 30 day supply of Prescription Drugs and Related Supplies.

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. a 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.

Advanced Premium Tax Credit (APTC) means a federal subsidy available to individuals and families seeking to purchase health insurance who earn less than 400% of the Federal Poverty Level (FPL). This subsidy helps to pay for their health insurance Premiums in order to make their health insurance more affordable.

Annual, Calendar Year, Year means a 12-month period beginning each January 1 at 12:01 a.m. Central 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.

Applied Behavior Analysis means 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.

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.

Benefit Schedule The part of this EOC that identifies applicable Copayments, Coinsurance, Deductibles, and maximums.

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.

Brace is 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.

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

Business Decision Team is a committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make recommendations regarding coverage treatment of Prescription Drugs and Related Supplies based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drugs and Related Supplies.

Charges means the actual billed Charges; except when the Provider has contracted with Cigna for a different amount.

Cigna means Cigna HealthCare of IL, Inc. a health maintenance organization (HMO) which is organized under the laws of the State of IL. 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 or his/her designee charged with the direction and management of Participating Physicians.

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 EOC network, and is only available for services detailed under "Cigna Telehealth Connection" in the "Covered Services and Benefits" section of this EOC.

Civil Union means both same-sex and different-sex couples are allowed to enter into a Civil Union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

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

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.**

Cost Share is the Deductible, Copayment and Coinsurance amounts You are responsible to pay under the EOC.

Covered Expenses means expenses that are incurred for Covered Services under this EOC and that Cigna will consider for payment under this EOC. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The Maximum Reimbursable Charge for Covered Services from Non-Participating Providers.

Covered Expenses may also be limited by other specific maximums or terms described in this EOC. Covered Expenses are subject to any applicable Deductibles and other benefit limits. An expense is incurred on the date the Member receives the service or supply for which a claim is made. Covered Expenses may be less than the amount that is actually billed.

Covered Services means 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) if 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.

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 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 mean calendar days unless expressly stated otherwise.

Deductible means the amount of Covered Expenses each Member pays for Covered Services each Year before benefits are available under this EOC.

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

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, including insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies; podiatric appliances for the prevention of complications associated with diabetes; the repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

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

Diabetes Pharmaceuticals & Supplies include, but are not limited to, blood glucose monitors on Cigna's Prescription Drug List; test strips for blood glucose monitors; specific blood glucose monitors; visual reading and urine test strips; tablets that 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 needleless systems; syringes and needles; biohazard disposal containers; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Durable Medical Equipment means 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.

Essential Health Benefits means Covered Expenses 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 IL, Inc. Individual plan Evidence of Coverage document, the Benefit Schedule, any Supplemental Riders and any other attachments described herein, the Enrollment Application, and any subsequent amendment or modification to any part of the EOC.

Experimental, Investigational and Unproven Procedure

a drug, device, medical treatment or procedure is considered Experimental, Investigational or Unproven if::

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

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

Family Deductible

means the deductible applied 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 Benefit Schedule for this EOC.

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 and 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 Prescription Drug Covered 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 Benefit Schedule section of this EOC.

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 means 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 means occupational therapy, physical therapy, speech therapy and other services that are prescribed by the Member's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

Home Health Agencies and Visiting Nurse Associations

means 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 “Covered Services and Benefits” Section.

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

Indian Health Program is defined as follows:

With respect to a Member who is a Native American or an Alaska Native only, the term "Indian Health Program" means:

- any health program administered directly by the Indian Health Service;
- any Tribal Health Program; and

any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 47 of US Title 25, Chapter 2.

Individual Deductible is the amount of Covered Expenses incurred from Participating Providers, for medical and Prescription Drug Covered Services, that You must pay each Year before any benefits are available. The amount of the Individual Deductible is described in the Benefit Schedule.

Individual Out-of-Pocket Maximum The Individual Out-of-Pocket Maximum is an accumulation of Covered Expenses. It includes Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered 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 Benefit Schedule section of this EOC.

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.

Limited Distribution Drugs (LDDs) are drugs with special requirements used to treat conditions affecting only a small percentage of the population. Because of this, the manufacturer may choose to limit the distribution of the drug to only a few pharmacies, or as recommended by the Food and Drug Administration (FDA) for the drug as a condition of its approval of the drug. This type of restricted distribution helps the manufacturer to monitor the inventory of the drug, educate the dispensing pharmacists about the required necessary monitoring, and ensure that any associated risks are minimized.

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

Maximum Reimbursable Charge

is the amount that Cigna will consider Covered Expense for a Non-Participating Provider. Cigna calculates the Maximum Reimbursable Charge as follows:

- **For Covered Expenses for Emergency Services performed by a Non-Participating Provider in the Emergency Department of a Hospital or Emergency Services delivered in the Emergency Department of a Non-Participating Hospital or facility,** the amount agreed to by the Non-Participating Provider or Hospital and Cigna or, if no amount is agreed to, **the greatest of**:
  - The median amount negotiated with Participating/In-Network Cigna Providers for the same services, or
  - The maximum amount Cigna would pay for a non-Emergency Out-of-Network Provider, or
  - The amount payable under the Medicare program, not to exceed the Non-Participating Provider's billed charges.
- **For Covered Expenses for non-Emergency Services, the lesser of**:
  - The Provider's normal charge for a similar service or supply; 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 "Covered Services and Benefits" section.

Medically Necessary/ Medical Necessity

means services or supplies that are determined by the Cigna Medical Director to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Not primarily for the convenience of any Member, Physician, or another Provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- 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.
- The most appropriate procedure, supply, equipment or service which can be safely provided 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.

The fact that a Provider prescribed, ordered, recommended or approved a service, supply, treatment or Confinement does not in and of itself make it Medically Necessary or a Medical Necessity.

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, psychosis and Serious Mental Illness.

Negotiated Rate Is the lesser of billed charges or the rate of payment that has been negotiated with a Participating Provider for Covered Services.

Newborn means an infant within 31 days of birth.

Network Specialist means a specialty-practice Physician who is part of the EOC's HMO Participating Provider Network at the time services are rendered.

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.

Non-Participating Pharmacy (Out-of-Network Pharmacy) is a retail Pharmacy which Cigna has NOT contracted with to provide Prescription Drug services to Members; or a home delivery with which Cigna has NOT contracted to provide mail-order Prescription Drugs services to Members.

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

Orthoses and Orthotic Devices are orthopedic appliances or apparatuses used to support, align, prevent or correct deformities.

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 Care Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.

Other Participating (In-Network) Health Care 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 that is licensed as an acute care Hospital under applicable state law and that has an agreement with Cigna to provide Hospital Services to Members.
Participating Pharmacy (In-Network Pharmacy)	means a retail Pharmacy with which Cigna has contracted to provide Prescription Drug services to Members; or a designated mail-order Pharmacy with which Cigna has contracted to provide mail-order Prescription Drug 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 Care 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.
Pharmacy & Therapeutics (P&T) Committee	is a committee comprised of both voting and non-voting Cigna employed clinicians, medical directors and pharmacy directors and non-employees such as Participating Providers that represent a range of clinical specialties. Consistent with applicable regulatory requirements, the P&T Committee regularly reviews Prescription Drugs and Related Supplies, including new Prescription Drugs and Related Supplies, for safety and efficacy; the findings of these clinical reviews enable the Business Decision Team to make coverage status recommendations. The P&T Committee's review may be based on the U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.
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.
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).

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 and the Business Decision Team. The Prescription Drug List is reviewed and updated 4 times a year to add new drugs or to move drugs to lower-cost tiers. Changes such as removing drugs from the Prescription Drug List, or determining which drugs will require Step Therapy or Prior Authorization are made once each Year on the Plan renewal date. 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	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 or her as the Physician principally responsible for their medical care.
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 EOC. 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 .

Prostheses/Prosthetic Appliances and Devices are artificial devices designed to replace wholly or partly, an arm or leg. Prostheses/Prosthetic Appliances and Devices include, but are not limited to:

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

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.

Qualified Health Plan (QHP) means an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act.

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 means 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 or pediatric dental 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

means 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.

Serious Mental Illness

Means the following: schizophrenia, paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), pervasive developmental disorders, obsessive-compulsive disorders, depression in childhood and adolescence, panic disorder, anorexia nervosa, bulimia nervosa and post-traumatic stress disorders (acute, chronic, or with delayed onset).

Service Area

means any place that is within the cities, counties and/or zip code areas in the state of IL that Cigna has designated as the Service Area for this EOC, 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 and that:

- is licensed and operated pursuant to state law;
- is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician;
- provides continuous 24-hours-per-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.), and
- maintains 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 http://www.cigna.com/ifp-drug-list 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 is a Prescription Drug or medical pharmaceutical considered by Cigna to be a Specialty Medication based on the following factors, subject to applicable law:

- the Prescription Drug or medical pharmaceutical is prescribed and used for the treatment of complex, chronic or rare conditions, and
- the Prescription Drug or medical pharmaceutical has a high acquisition cost; and:
  - the Prescription Drug or medical pharmaceutical is subject to limited or restricted distribution,
  - requires special handling
  - and/or requires enhanced patient education, provider coordination or clinical oversight.

A Specialty Medication may not possess all or most of the above listed characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug or medical pharmaceutical will be considered a Specialty Medication.

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.

Splint is an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Stabilize	means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
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 http://www.cigna.com/ifp-drug-list.
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	means the following mental disorders as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association: (A) substance abuse disorders; (B) substance dependence disorders; and (C) substance induced disorders.
Synchronization/Synchronized	means the coordination of Prescription Drug refills for a Member taking 2 or more Prescription Drugs for one or more chronic conditions such that the Members Prescription Drugs are refilled on the same schedule for a given time period.
Telehealth/Telemedicine Medical Service	means a health care service initiated or provided by a Physician for purposes of patient assessment, diagnosis, consultation, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology.
Terminal Illness/ 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.
Tribal Health Program	**means, with respect to a Member who is a Native American or an Alaska Native only,** an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

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.
Virtual	with respect to Cigna Telehealth Connection, means Covered Services that are delivered via secure telecommunications technologies, including telephones and internet.
We/Us/Our	Cigna HealthCare of IL, 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 IL. 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 IL; and
- Live within the Service Area of this EOC; 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 the Subscriber's lawful spouse or partner to a civil union and reside in the Service Area; or
- Be a child of the Subscriber by birth, adoption pursuant to an interim court order of adoption (whether or not the child lives with the Subscriber), or foster care who has not yet reached age 26; or
- Be a stepchild of the Subscriber who has not yet reached age 26; or
- Be an unmarried military veteran dependent who has not yet reached age 30 if the veteran (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible, the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.
- Be the Subscriber's or the Subscriber's spouse's or Subscriber's partner to a civil union's unmarried children, regardless of age, enrolled prior to age 26, who are incapable of self-sustaining employment and are dependent upon his/her parents or other care providers for lifetime care and supervision. Cigna requires written proof of such disability and dependency within 31 days after the child's 26th birthday.
- The Subscriber's or the Subscriber's Spouse's or Subscriber's partner to a civil union'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 a 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.

- An adopted child, including a child who is placed with You for adoption is automatically covered for 31 days from the date of adoption or initiation of a suit of adoption. To continue coverage past that time, You must enroll the child as a dependent 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 a court has ordered a Subscriber 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 a dependent Member by applying for his or her enrollment as a dependent within 60 days of the court order date, and paying any additional Premium. 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.

NOTE: A child eligible to enroll as a Dependent under this EOC who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Covered Services and Benefits" section.

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 Annual Open Enrollment Period must wait until the next Annual 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 Annual 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 EOC, 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) loses 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 losing 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 (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; or
- An eligible individual losing 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 gaining such status; or
- An eligible individual's enrollment or non-enrollment in a qualified health plan unintentional, inadvertent or erroneous, and as the result of the error, intentional 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, intentional 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); or

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, or 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.

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
- An eligible 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; 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 Advanced Premium Tax Credit (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 Marketplace 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 Marketplace 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:

- If Cigna determines that any Member covered under this EOC has engaged in fraud or intentional misrepresentation of facts with respect to the Member's application for, coverage under, or receipt of benefits pursuant to this EOC;
- When Premiums are not paid according to the due dates and grace periods described in the Premium Section;
- For a 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; or
- 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 a 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 qualifying as Dependents for coverage under this EOC, for any reason except for the Subscriber's failure to pay Premium, that Member has the right to continuation of his or her insurance. Coverage will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly Premium within 60 days following the date this EOC would otherwise terminate. In such a case, 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 Member any Premiums paid by Member under this EOC for the period of any such duplicate enrollment.

EFFECTIVE DATE OF COVERAGE

Subject to the provisions of this EOC, including payment of applicable Premiums in accordance with the "Payments" Section 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.

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

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.

If You did not purchase Your EOC from a Marketplace, or You purchased Your EOC from a Marketplace but did not elect to not receive Advanced Premium Tax Credit, there is a grace period of thirty-one (31) days during which any Premium due after the first Premium may be paid without loss of coverage. Coverage will continue during the grace period. If We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as the last date for which You have paid Premiums.

If You did purchase Your EOC from a Marketplace and You have elected to receive Advanced Premium Tax Credit, there is a grace period of ninety (90) days during which the Premiums may be paid without loss of coverage. Coverage will continue during the grace period however, claims for services rendered after the first 30 days of the grace period will be either pended or denied until such time as your Premium is paid. If We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period.

Please see the provisions titled “Cancellation” and “Reinstatement” for further information regarding cancellation and reinstatement. 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 EOC 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. If You purchased Your Plan from a Marketplace and You have elected to receive Your Advanced Premium Tax Credit, Cigna shall permit a grace period of ninety (90) days during which the Premiums may be paid without loss of coverage. If payment is not received within the grace period, the EOC may be terminated by Cigna pursuant to the “Specific Causes of Ineligibility” provision of the “Eligibility” Section. In no event shall Cigna have any obligation to provide a reminder notice for Premiums which are not received prior to the expiration of the grace period. Only Members for whom the payments are actually received by Cigna shall be entitled to health care services hereunder, and then only for the period for which payment is received.

If You purchased Your EOC from a Marketplace and You have elected to receive Your Advanced Premium Tax Credit, Your grace period is extended for three consecutive months provided you have paid at least one full month's Premium during the benefit year. Coverage will continue during the grace period, and claims for services rendered after the first 30 days of the grace period will be either pended or denied until such time as your Premium is paid. If We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period. Please see the provisions titled “Cancellation” and “Reinstatement” for further information regarding cancellation and reinstatement.

Member Payments

You are required to pay all Copayments and Member Coinsurance for services rendered. Copayments and Coinsurance are subject to change upon plan renewal once per Year. You are liable for all Copayments and Coinsurance incurred by Yourself and any of Your Dependents. See Your Benefit Schedule for further detail.

The monthly Premium amount is listed on the EOC specification page which was sent with this EOC.

You will be responsible for an additional $45 charge for any check or electronic funds transfer that is returned to Us unpaid. This additional charge is part of your Premium obligation**.** You will not be considered to have paid Your Premium until Your Premium amount and any additional charge**s** incurred by You are received by Cigna.

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

a. Deletion or addition of a new eligible Insured Person(s)
b. A change in age of any Insured Person which results in a higher Premium
c. A change in residence
d. Application of any additional charges as a result of a late or returned payment

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

Cigna also reserves the right to change the Premium on 60 days' prior written notice to You. However, We will not modify the Premium schedule on an individual basis, but only for all Insured Persons in the same class and covered under the same Policy as You. The change will become effective on the date shown on the notice, and payment of the new Premiums will indicate acceptance of the change.

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 Dependents or an Acceptable Third Party Payor, except as expressly permitted by Cigna in writing. Cigna may request and upon request, You shall provide, a certified statement from You that You are not receiving payment or other remuneration from anyone other than an Acceptable Third-Party Payor as defined above for the partial or full payment of Your premium or other cost-sharing obligations under this EOC.

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 Benefit Schedule, 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 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.

The Covered Services for which benefits are provided under this EOC are limited to the most cost effective and clinically appropriate treatment, supply, or service as defined by Cigna.

Physician Services

Coverage is provided for 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, under this EOC coverage is provided for 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

Coverage is provided for 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

Coverage is provided for 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, chemotherapy and hemodialysis; 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

For any eligible condition that is authorized by Cigna, this EOC provides indicated benefits for Covered Expenses for inpatient services and supplies provided by an Other Participating Health Care Facility, except private room charges above the prevailing two-bed room rate of the facility. Payment of benefits for Other Participating Health Care Facility services is subject to all of the following conditions:

- The Member must be referred to the Other Participating Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by an Other Participating Health Care Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury, subject to any maximum number of covered days per Year shown in the Benefit Schedule.
- Services covered under this benefit cannot be provided in a less intense setting, such as outpatient services provided at home.
- The Member must remain under the active medical supervision of a Physician treating the Illness or Injury for which he or she is confined in the Other Participating Health Care Facility.

Note: No benefits will be provided for:

- Personal items, such as TV, radio, guest trays, etc.

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 Primary Care Physician or the CIGNA HealthCare 24-Hour Health Information Line [SM] as soon as possible for further assistance and advice on follow-up care. If You require specialty care or a hospital admission, Your Primary Care Physician or the Cigna HealthCare 24-Hour Health Information Line [SM] will coordinate such care or admission and handle the necessary authorizations for care or admission. Participating Providers are on call twenty-four (24) hours per day, seven (7) days per week, to assist you when You need Emergency Services.

If You receive Emergency Services outside the Service Area, you or the Emergency Services Provider must notify Us as soon as reasonably possible. Any post-stabilization services rendered to you following the Emergency Treatment must be authorized by Your PCP or Cigna. We may arrange to have You transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

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

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

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

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

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from Non-Participating (Out-of-Network) Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through Non-Participating (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

Coverage is provided for ambulance services to the nearest appropriate Provider or facility for treatment of an Emergency Medical Condition.

Autism Spectrum Disorders

Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorder(s) on the same basis as benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for a Member diagnosed with an Autism Spectrum Disorder by:

(a) a Physician or a Psychologist who has determined that such care is Medically Necessary, or,

(b) a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas:
  - a) self care and feeding,
  - b) pragmatic, receptive and expressive language,
  - c) cognitive functioning,
  - d) applied behavior analysis (ABA), intervention and modification,
  - e) motor planning and
  - f) sensory processing.

Bariatric Services

Coverage is provided for Medically Necessary bariatric surgery, subject to all plan Referral and Authorization requirements.

Blood and Blood Components

Coverage is provided for clotting factors necessary for the treatment of blood disorders, including hemophilia. Coverage is also provided for blood transfusions.

Breast Cancer Pain Medication and Therapy

Coverage is provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined

goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this EOC.

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 can access Cigna Connection Telehealth 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 the "Definitions" section of this EOC for a complete description of the services.

Clinical Trials – Routine Care Cost

Benefits are payable for routine patient care costs 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 conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna for 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 care costs do not include:

- the investigational item, device, or service itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- transportation, lodging, food or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted;
- any service, item or drug that is provided by a clinical trial sponsor free of charge for any new patient; or
- any service, item or drug that is eligible for reimbursement from a source other than a covered individual's policy, including a sponsor of the clinical trial.

Clinical trials conducted by Non-Participating Providers will be covered at the in-network benefit level if:

- there are not In-Network Providers participating in the clinical trial that are willing to accept the individual as a patient; or

- the clinical trial is conducted outside the individual's state of residence.

Cosmetic Surgery

Cosmetic Surgery is covered only for reconstructive surgery that constitutes Medically Necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Treatment of congenital defects and birth abnormalities is covered for eligible Dependent children.

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.

Dental Care

This EOC provides benefits for dental care for an accidental Injury to 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 natural teeth due to chewing or biting is not considered an accidental Injury under this EOC.

Dental Procedures Hospitalization/Anesthesia

- Coverage is provided for Hospital or facility and anesthesia services related to dental procedures in order to safely and effectively perform a dental procedure for a member who: is a child;
- has a medical condition that requires hospitalization or general anesthesia for dental care; or
- have a chronic mental or physical disability that substantially limits one or more major life activities

Diabetic Services and Supplies

Coverage is provided for Diabetic services for insulin-using Members, non-insulin using Members and Members with elevated blood glucose levels due to pregnancy. Services consisting of physician visits upon the diagnosis of diabetes; visits following a physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with authorizing authority; and medical nutrition therapy related to diabetes management.

Diabetic supplies including insulin; syringes and needles; pre-filled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips, visual reading ketone strips and urine test strips; injection aids (i.e. lancets, alcohol swabs); glucometers, blood glucose monitors for the legally blind; insulin pumps, infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits.

Durable Medical Equipment

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

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

Note: 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. Coverage for Durable Medical Equipment is limited to the most cost-effective alternative.

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

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

Coverage for repair, replacement or duplicate equipment is provided only when approved as Medically Necessary. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

Eosinophilic Gastrointestinal Disorder

Coverage is provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.

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 EOC provides benefits for Covered Expenses for services and supplies received from Foreign Country Providers only for Emergency Medical Conditions 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 EOC and will not be more than would be paid if the service or supply had been received in the United States

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.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent of a Member has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if covered genetic testing is planned or if a Member is at risk for an inherited disease or carrier state.

Habilitative Services

Coverage is provided 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.

Coverage is provided for Covered Expenses for the Medically Necessary care and treatment of loss or impairment of speech, as stated in the Benefit Schedule.

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided. All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

Limits on the number of visits provided under the Rehabilitative benefit do NOT apply to Habilitative Services.

Hearing Aids

Coverage is provided for hearing aids for children and bone anchored hearing aids (osseointegrated auditory implants), to any limit shown in the Benefit Schedule.

Hearing Examination

Coverage is provided for routine pediatric hearing examinations.

Home Health Services

This EOC includes benefits for Covered Expenses for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility. Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals, including Medically Necessary services of a medical social worker. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 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 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 Health Care Professional. 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.

This EOC provides benefits for Covered Expenses for Home Health Care prescribed by the Physician treating your condition when the following criteria is met:

- The care described in the plan of care must be for intermittent skilled nursing, or Physical, Occupational, and other Rehabilitative Therapy services.
- The Member must be confined at home, in lieu of hospitalization, under the active supervision of a Physician.
- The home health agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care

The Physician must be treating the Illness or Injury that necessitates home health care.

If the Member is a minor or an adult who is dependent upon others for non-skilled care, Custodial Care and/or activities of daily living (e.g., bathing, eating, etc.), Home Health Care will be covered only during times when there is a family member or care giver present in the home to meet the Member's non-skilled care and/or Custodial Care needs.

Hospice Care

This EOC provides benefits for Covered Expenses for Hospice Care under a Hospice Care Program for Members who have a Terminal Illness and for the families of those persons 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 counseling for the families for up to 12 months following the death of the terminally ill Member.

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

In order to be eligible for benefits for a Hospice Care Program, the Member must be suffering from a Terminal Illness, as certified by his or her Physician, notice of which is submitted to Us in writing.

The Physician must consent to the Hospice Care Program, and must be consulted in the development of the treatment plan.

Infertility

Coverage is provided on the same basis as for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to: in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

For the purposes of this benefit, Infertility means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one year requirement will be waived if Your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to: congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

For the purposes of this benefit, Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments, (however, this requirement will be waived if you or your partner has a medical condition that makes such treatment useless); and You have not undergone four completed oocyte retrievals under this plan, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals that are eligible for coverage under this EOC is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to you. Thereafter, you will have no benefits for infertility treatment.

Special Limitations

Infertility Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.

4. Non-medical costs of an egg or sperm donor.
5. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Cigna.
6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
7. Infertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

Internal Prosthetic/Medical Appliances

Coverage is provided for Internal Prosthetic/Medical Appliances, including but not limited to cochlear implants that are authorized by the Primary Care Physician and includes 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

Coverage is provided for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

Mastectomy and Related Procedures

Coverage is provided 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.

Inpatient coverage following a mastectomy for a length of time determined by the attending physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient and the coverage for and availability of a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the 48 hours after discharge.

Breast implant removal and subsequent reconstructive surgery are covered when Medically Necessary to treat a sickness or injury.

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 EOC.

Maternity Care Services

Coverage is provided for 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 for You and Your Dependents, including pregnancy of dependent children. Coverage includes prenatal HIV testing when ordered by a, or under the supervision of a Physician.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section. We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a Provider obtain authorization for prescribing a length of stay that does not exceed the above periods. 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.

In the event that the mother and newborn are discharged prior to 48/96 hours, coverage shall be provided for one (1) postpartum home care visit or physician office visit within 48 hours of discharge.

Medical Supplies

Coverage is provided for Medically Necessary medical supplies that 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. If a medical supply is specifically excluded from coverage by another provision of this EOC, this paragraph will not be construed to provide coverage for that supply.

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.

Mental Health Residential Treatment Services

Includes court-ordered services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions. Mental Health Services Residential Treatment Center means an institution which

a. specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions;

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 Mental Health Services Residential Treatment Center when he/she is a registered bed patient in a Mental Health Services Residential Treatment Center upon the recommendation of a Physician.

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, structured group, intensive outpatient structured therapy program, or partial hospitalization. Covered Services include, but are not limited to, outpatient testing, assessment, and medication management when provided in conjunction with a consultation, and 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),

Intensive Outpatient Mental Health Services

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 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. The Cigna Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Substance Use Disorder Residential Treatment Services

Includes court-ordered 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 Center means an institution which

- specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder;
- provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;
- provides twenty-four (24) hour care, in which a person lives in an open setting; and

- 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/she is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services for the diagnosis and treatment of use disorder or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group, intensive outpatient structured therapy program, or partial hospitalization.

Intensive Outpatient Structured Therapy Programs

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.

Excluded Mental Health and Substance Use Disorder Services

Mental Health and Substance Use Disorder services that are not covered by this EOC are listed in the EOC under “Benefit Exclusions and Limitations”.

Obstetrical and Gynecological Services

Coverage is provided for 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 and Supplies 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.

Osteoporosis Services

Coverage is provided for services related to Medically Necessary bone mass measurement and for the diagnosis and treatment of osteoporosis on the same terms and conditions as other medical conditions.

Ostomy Supplies

Coverage is provided for ostomy supplies that are Medically Necessary 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 is provided within the Service Area for oxygen that is routinely used on an outpatient basis. Oxygen Services are not covered outside of the Service Area, except on an emergency basis.

PANDAS and PANS

(Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute Onset Neuropsychiatric Syndrome)

Your benefit plan includes coverage for those services required under Illinois state law for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, and pediatric acute onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.

Pediatric Dental Care

If You did not purchase Your Plan from a Marketplace, coverage is provided for pediatric dental care for Members less than 19 years of age in the Pediatric Dental Care policy in which the Member is enrolled. Pediatric Dental Care policy benefits are subject to all the terms and conditions of the Pediatric Dental Care policy.

Pediatric Vision Care 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 this limiting age is reached.

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

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

Pediatric Vision Services means routine vision care examinations, preventive treatment and other services or treatment described in the "Pediatric Vision Services" section of this EOC provided to a Member who is under age 19. **Benefits will apply until the end of the month in which this limiting age is reached.**

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 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 the bioptic telescope, 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.

Pediatric Vision Care 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;
- any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related;
- Charges in excess of the usual and customary charge for the Service or Material;
- charges incurred after the EOC ends or the Member's coverage under the EOC ends, except as stated in the EOC;
- Experimental or Investigational or Unproven or non-conventional treatment or device;
- magnification or low vision aids not otherwise listed in the Covered Benefits section, above;
- any non-prescription eyeglasses, lenses, or contact lenses;

- spectacle lenses, treatments, “add-ons”, or lens coatings not otherwise specified as a covered service or supply within this section;
- two pair of glasses, in lieu of bifocals or trifocals;
- safety glasses or lenses required for employment;
- VDT (video display terminal)/computer eyeglass benefit;
- Prescription sunglasses;
- High Index lenses of any material type
- for, or in connection with, Experimental or Investigational or Unproven 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, or to get a claim form, the Member should visit **myCigna.com** and use the link on the vision coverage page, or they may call Member Services using the toll-free number on their identification card.

Preventive Care Services/Periodic Health Examinations

Coverage is provided for routine preventive care services. Payment will be provided for Covered Expenses for preventive care services including the following:

- Routine physical exams, including but not limited to the following preventive screenings and counselling:
  - Blood pressure screening;
  - Obesity screening and counseling;
  - Diet counseling for adults at higher risk for chronic disease;
  - Aspirin use for men and women of certain ages;
  - Sexually transmitted infections (STI) prevention;
  - Depression screening
  - Alcohol misuse screening and counseling;
  - Tobacco use screening and cessation interventions for tobacco users.
- Annual Pap test.
- Screening by low-dose mammography for all women over age 35 as follows:
  - Baseline mammogram for women ages 35-39 and annual mammogram for women age 40 and older;
  - For women under age 40 with a family history of breast cancer or other risk factors, mammograms will be covered at an age and interval considered Medically Necessary;
  - Coverage includes both (a) a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when

Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches; and (b) a screening MRI when Medically necessary, as determined by a Physician.

- Low-dose mammography screenings are covered at no cost, subject to the conditions above.

For purposes of this benefit, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. With respect to this benefit, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

- Prostate Cancer Screening, including Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of a physician for:
  - asymptomatic men age 50 and over;
  - African-American men age 40 and over;
  - men age 40 and over with family history of prostate cancer.
- Lung Cancer Screening annually with low-dose computed tomography for adults age 55 and over who have a 30 pack/year smoking history, and currently smoke or have smoked within the past 15 years;
- Cholesterol screening for adults of certain ages or at higher risk;
- Type 2 diabetes screening for abnormal blood glucose for adults with high blood pressure and/or as part of a cardiovascular risk assessment in adults age 40 and over who are overweight or obese;
- HIV screening for everyone ages 15-65;
- HIV screening for all adults at higher risk, and syphilis screening for adults at higher risk;
- Hepatitis C screening for persons at high risk of infection;
- Abdominal aortic aneurysm screening for men who have ever smoked;
- Colorectal cancer screening for adults over age 50;
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diptheria, Pertussis and Varicella:
- Vaccine for shingles that is approved by the United States Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine in all its branches and the enrollee is 60 years of age or older;
- Fall prevention in older adults;
- 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, including but not limited to:
  - Congenital hypothyroidism screening, hearing screening, hemoglobinopathies or sickle cell screening and Phenylketonuria (PKU) screening for all newborns;

- Gonorrhea preventive medication for the eyes of all newborns;
- The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary): Hepatitis A, Hepatitis B, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diptheria, Pertussis, Varicella, Haemophilus Influenzae Type B, Rotavirus and Inactivated Poliovirus;
- any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Development screening for children under age 3, and surveillance throughout childhood;
- Oral health risk assessment for younger children;
- Vision screening for all children, and medical history for all children throughout development;
- Fluoride chemoprevention supplements for children without fluoride in their water source starting at age 6 months; primary care clinicians should apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;
- Lead screening for children at risk for exposure, and tuberculin testing for children at higher risk of tuberculosis at the following ages as part of a well-child visit:
    - 0-11 months;
    - 1-4 years;
    - 5-10 years;
    - 11-14 years; and
    - 15-17 years;
- Behavioral assessments and blood pressure screenings for children of all ages;
- Autism screening provided without regard to the Covered Person's age
- Dyslipidemia screening for children at higher risk of lipid disorder;
- Height, weight and body mass index measurements;
- Obesity screening and counseling;
- Hematocrit or hemoglobin screening;
- Depression screening for adolescents;
- Alcohol and drug use assessment for adolescents;
- Cervical dysplasia screening for sexually active females;
- HIV prevention education and risk assessments annually in adolescents;
- HIV screening and sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk;
- Tobacco use screening, and cessation interventions including education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents, for tobacco users;
- Skin cancer behavioral counseling for young adults, adolescents, children and parents of young children from age 6 months to 24 years.

- For women, including pregnant women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to:
    - Well woman visits to obtain recommended preventive services;
    - BRCA counseling about genetic testing and breast cancer chemoprevention counseling for women at higher risk;
    - Gonorrhea screening for all women at higher risk;
    - Chlamydia infection screening for younger women and women at higher risk;
    - Screening for urinary incontinence;
    - Cervical cancer screening, HIV screening and counseling and sexually transmitted infections (STI) counseling for sexually active women;
    - HIV prevention education and risk assessment in women at least annually throughout their lifespan;
    - Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
    - Osteoporosis screening for women over age 60, depending on risk factors;
    - Domestic and interpersonal violence screening and counseling for all women;
    - Alcohol misuse screening and counseling;
    - Tobacco use screening and cessation interventions for tobacco users, and expanded counseling for pregnant tobacco users;
    - Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
    - Folic acid supplements for women who may become pregnant;
    - Low-dose aspirin (81 mg/day) after 12 weeks of gestation for women who are at high risk for preeclampsia;
    - Hepatitis B screening for pregnant women at their first prenatal visit;
    - Syphilis screening for all pregnant women or other women at increased risk;
    - Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
    - Anemia screening on a routine basis for pregnant women;
    - Bacteriuria urinary tract screening or other infection screening for pregnant women;
    - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
    - Screening for diabetes after pregnancy;
    - Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, including coverage of the rental of one breast pump per birth up to the purchase price as ordered or prescribed by a Physician for pregnant and nursing women.
    - Clinical breast examination

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.

Prosthetics and Orthotics

External Prosthetic Appliances and Devices

This EOC provides benefits for Covered Expenses made or ordered by a Physician for the initial purchase and fitting of External Prosthetic Appliances and Devices available only by prescription which are Medically Necessary for the alleviation or correction of Illness, Injury, or congenital defect.

External Prosthetic Appliances and Devices include Prostheses/Prosthetic Appliances and Devices, Orthoses and Orthotic Devices; Braces; and Splints.

Coverage for External Prosthetic Appliances and Devices is limited to the most appropriate and cost effective alternative. 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.

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, when Medically Necessary 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.

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.

Frequency of 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 EOC:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.
- Electronic prosthetic limbs or appliances are not covered unless Medically Necessary, when a less-costly alternative is not sufficient

The following orthoses & Orthotic Devices are specifically excluded from coverage under this EOC, unless provided in the Diabetic Services and Supplies benefit:

- Prefabricated foot Orthoses;
- Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly;
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for cosmetic rather than functional reasons; and
- Non-foot Orthoses, except **only** the following non-foot orthoses are covered when Medically Necessary:
    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.

Braces

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

- Copes scoliosis braces.

Reconstructive Surgery

Coverage is provided for Medically Necessary reconstructive surgery or therapy for medically diagnosed congenital defects and birth abnormalities. Additionally, reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit provided that:

1. the surgery or therapy restores or improves function or decreases risk of functional impairment;
2. reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
3. the surgery or therapy 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 Rehabilitative Therapy
(Physical Therapy, Occupational Therapy, Speech Therapy)

Occupational Therapy

Coverage is provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physical Therapy

Coverage is provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Coverage is provided 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 neuromusculoskeletal 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.

Coverage is also provided for preventive or Maintenance Physical Therapy when prescribed for persons affected by multiple sclerosis.

Speech Therapy

Coverage is provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Coverage is provided for Covered Expenses 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 Covered Supplies and additional fees properly 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.

Pulmonary and Cardiac Rehabilitation

This EOC provides benefits for Covered Expenses incurred for pulmonary rehabilitation, and for phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The phase II program must be Physician directed with active treatment and EKG monitoring.

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

Naprapathic Services

Coverage is provided for Naprapathic Services on the same basis as your benefits for any other condition to any visit limit shown in the Benefit Schedule.

Chiropractic Services

Coverage is provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures to any visit limit shown in the Benefit Schedule.

Massage Therapy Services

Coverage is provided for Medically Necessary massage therapy for treatment of an illness or injury.

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

Coverage is limited to therapy services that are 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 by the Cigna Medical Director to be 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.

Treatment for Temporomandibular Joint Disorder/Dysfunction

Coverage is provided for medical services for temporomandibular joint disorder or dysfunction (TMJ/TMD) that is the result of an accident, trauma, a congenital defect, a developmental defect or pathology, on the same basis as any other medical condition.

Covered Expenses include diagnosis and treatment of TMJ/TMD that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ/TMD, including intra-oral splints that stabilize the jaw joint.

Organ and Tissue Transplants and Related Specialty Care

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. This coverage is subject to the following conditions and limitations.

Coverage is provided for both the recipient and donor of a covered transplant under the recipient's plan.

Coverage will be provided for:

1. Inpatient and Outpatient Covered Services related to the transplant surgery. Transplant services include the recipient's 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.
2. Cornea transplants are not covered by the LifeSOURCE Provider contracts, but are covered when received from a Participating Provider facility.

3. 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 deceased 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.

No accident and health insurer may deny reimbursement for an organ transplant as Experimental or Investigational unless supported by appropriate, required documentation.

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: Most 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 not be covered. For more information on whether an In-Network facility is contracted with Cigna to provide transplant services, call the number on Your ID card.

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:

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

In addition to You being covered for the Covered Services associated with the items above, such charges 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.

Note: Covered travel expenses under this EOC are subject to the following limits:

- per-day limit
- per transplant limit
- overall maximum benefit limit

Travel expenses that are NOT covered include, but are not limited to the following:

1. travel costs incurred due to travel within fifty (50) miles of Your home;
2. food and meals;
3. laundry bills;
4. telephone bills;
5. alcohol or tobacco products; and

6. 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.

Travel expenses for organ and tissue transplants are limited to a maximum shown in the Benefit Schedule.

Other Services Available through LifeSOURCE Facilities

The following services are covered but ONLY when provided at a Cigna LifeSOURCE Transplant Network facility. The services are not covered when provided by any other Provider, including any other Cigna Participating Provider:

- **Ventricular Assist Device**
  Ventricular Assist Device (VAD) implantation procedures are covered only when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved heart transplant program. VAD implantation procedures received at any other Providers are not covered.
- **Advanced Cellular Therapy**
  Advanced cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered only when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved stem cell transplant program. Advanced cellular therapy received at other facilities is not covered.

PRESCRIPTION DRUGS

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 Deductible shown in the Benefit Schedule, and once the Deductible is satisfied, subject to any applicable Copayment or Coinsurance shown in the Benefit Schedule. For additional information on the Deductible, please refer to the Definitions section of this EOC.

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

Member Payments

In the event that You or Your Physician requests 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 Summary.

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

- the Copayment or Coinsurance for the Prescription Drug, or
- Cigna's discounted rate for the Prescription Drug; or
- the Pharmacy's usual and customary charge for the Prescription Drug.

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

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

Prescription Drugs and Specialty Medication Covered as Medical

When Prescription Drugs and Specialty Medications covered by Cigna 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.

For certain Limited Distribution Drugs covered under the medical benefits of this EOC, the Provider who administers the drug must obtain the drug directly from a Cigna contracted Limited Distribution Drug Provider in order for that drug to be covered. If you have questions about the acquisition of the drugs being administered to You, please consult Your Provider.

Self-Administered Injectable and Non-Self-Administered Injectable Drugs and Specialty Medication Benefits

Drugs Covered under the Prescription Drug Benefits

Self-Administered Injectable Drugs, and syringes for the self-administration of those drugs, are covered under the Prescription Drug benefits of this EOC. To determine if a drug prescribed for You is covered, You can:

- log into Your myCigna.com account and
- view the Cigna Prescription Drug List at http://www.cigna.com/ifp-drug-list, and
- then choose the Cigna Prescription Drug List for Your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Drugs Covered under the Medical Benefits

Non-Self-Injectable Drugs and Injectable Specialty Medications on Cigna's Prescription Drug List are covered under the medical benefits of this EOC when:

Injectable Drugs and Injectable Specialty Medications on Cigna's Prescription Drug List are administered in a healthcare setting by a Physician or health care professional, and are billed with the office or facility charges.

You or Your Physician can view the Cigna Prescription Drug List by:

- accessing http://www.cigna.com/ifp-drug-list, and
- choose Your state.

Note: the drugs may be subject to Prescription Drug Prior Authorization or Step Therapy requirements.

Prescription Drug List Management

The Prescription Drug List is managed by the Business Decision Team, the team makes the final placement decision on the placement of a Prescription Drug in a certain coverage tier. Your plan's coverage tiers may contain Prescription Drugs that are Generic Drugs, Brand Drugs or Specialty Prescription Drugs. Placement of any Prescription Drug in a specific tier depends on a number of clinical and economic factors, such as a review and consideration of the P&T Committee's evaluations of the place of therapy, relative safety or relative efficacy of the Prescription Drug, and whether certain supply limits or other utilization management requirements should apply. Whether a particular Prescription Drug is appropriate for You or any of Your Dependents, regardless of its eligibility coverage under Your plan, is a determination that is made by You (or Your Dependent) and the prescribing Physician.

The coverage status of a Prescription Drug may change periodically for various reasons. For example, a Prescription Drug may be removed from the market, or a new Prescription Drug in the same therapeutic class may become available, or the cost of a Prescription Drug may increase.

As a result of coverage changes, Your Cost Share for that Prescription Drug could increase, or decrease or the drug may no longer be covered under this EOC. In that event, You may want to talk to Your Physician about switching to an alternative Prescription Drug. Please access www.mycigna.com through the Internet or call Member Services at the telephone number on Your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug.

Covered Expenses

If a Member, while covered under this EOC, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Benefit Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to 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 Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna as if filled by a Participating Pharmacy.

Covered Prescription Drugs 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 syringes(no prescription required); injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; l 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.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- Medically Necessary pain medication related to the treatment of breast cancer.
- All non-infused compound Prescriptions that contain at least one FDA approved Prescription ingredient compounded from an FDA approved finished pharmaceutical product and are otherwise covered under the Prescription benefits, **excluding** any bulk powders included in the compound.
- Contraceptive Drugs and devices approved by the FDA; a supply for up to a 12-month supply of contraceptives (including over-the-counter), devices and products, except male condoms, will be covered when dispensed or furnished at one time. You can view the No Cost Share Preventive Drug List which lists the drugs, devices and over-the-counter products that are covered at http://www.cigna.com/ifp-drug-list and open the document on the right side titled “No Cost Share Preventive Drug List”. If Your Physician believes You require a drug, device or over-the-counter product that is not on the list Your Physician may contact Cigna regarding a Medical Necessity exception. Please refer to the section of this EOC titled “Authorization, Exception and Appeal Process for Prescription Drugs and Related Supplies”.
- Specialty Medications
- Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of infertility with a written prescription
- Biological Drugs
- Inhalers prescribed for asthma or other life-threatening bronchial ailments will be allowed to be refilled prior to the time a refill may otherwise be obtained if Medically Necessary and ordered by a treating physician
- Prescription topical eye medication prescribed to treat a chronic condition of the eye will be allowed to be refilled prior to the last date of the prescribed dosage period and after at least 75% of the predicted days of use, when the prescribing Physician indicates on the original Prescription that

refills are permitted and that early refills requested by the Member do not exceed the total number of refills prescribed.

- Prescription opioid antagonist medications, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist are covered under this EOC. The coverage includes refills for expired or utilized opioid antagonists. For the purposes of this benefit, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.
- Cigna will provide for the Synchronization of Prescription Drug refills at least once per Year if all of the following conditions are met:
  - the Prescription Drugs are on the Prescription Drug List, covered by the plan clinical coverage policy or have been approved through the Prescription Drug List exceptions process;
  - are medications You take on an ongoing basis and have refill quantities available at the time of Synchronization;
  - are not narcotics (Schedule II, III, or IV controlled substances);
  - all of the drug utilization management criteria have been met;
  - the drugs are of a formulation that can be safely split into short-fill periods to achieve Synchronization; and
  - the Prescription Drugs do not have special handling or sourcing needs as determined by the Plan that require a single, designated pharmacy to fill or refill the Prescription.

  Cigna will only impose one Copay for the dispensing of the Synchronized Prescription Drugs that equal the prescribed dosage for those drugs. The Copay will apply to each 30 day supply. All dispensing fees will be based on the number of Prescriptions filled or refilled. Cigna will provide reimbursement forms for the additional Copay if the override is not in place prior to filling the Prescription.

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.
- Be approved for use by the Food and Drug Administration.
- Be 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 an Member’s illness.
- Be purchased from a licensed retail Pharmacy or ordered by mail Cigna’s Home Delivery Pharmacy Program.
- Not be used while the Member is an inpatient in any facility.
- 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 Exclusions

The following are not covered under this EOC. No payment will be made for the following expenses:

1. Drugs not approved by the Food and Drug Administration.
2. Drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process;

3. Drugs, devices and/or supplies, available over the counter that do not require a prescription by Federal or State Law, except as otherwise stated in this EOC, or specifically designated as No Cost Preventive Care and required by the Patient Protection and Affordable Care Act (PPACA).
4. Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin.
5. Drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
6. 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.
7. Any injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this 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.
8. Any drugs that are Experimental or Investigational or Unproven, within the meaning set forth in the EOC.
9. 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.
10. Any Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug and the Medically Necessary services associated with the administration of the drug are recognized as safe and effective for the treatment of the Member's specific cancer in at least one standard medical reference compendia or medical literature. Standard medical reference compendia include: The American hospital formulary service drug information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium; Other Authoritative Compendia as identified by the Secretary of the United States Department of Health and Human Services.
11. Any prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment.
12. Implantable contraceptive products are covered under the medical benefits of the EOC.
13. Any drugs used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy and decreased libido and/or sexual desire;.
14. 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) .
15. 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.
16. Any drugs used for weight loss, weight management, metabolic syndrome; and antiobesity agents.
17. 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.

18. Any medications used for travel prophylaxis, except for anti-malarial drugs.
19. Any drugs obtained outside of the United States.
20. Any fill or refill of Prescription Drugs and Related Supplies that is to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
21. Any drugs used to enhance athletic performance.
22. 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.
23. Any drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician
24. Drug convenience kits.
25. Any prescriptions more than one year from the original date of issue.
26. Any costs related to the mailing, sending or delivery of Prescription Drugs.
27. Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Member.

Prescription Drug Limitations

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

- Up to a 30 day supply at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 30 day supply of tier 5 Drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers refer to the Benefit Schedule); or
- Up to a 90 day supply, at a Participating 90 Day Retail Pharmacy for drug tiers 1 through 4 and up to a 90 day supply of tier 5 Drugs, unless limited by the drug manufacturer's packaging. To locate a Participating 90 Day Retail Pharmacy you can call the Member Services number on Your ID card or log on to www.cigna.com/ifp-providers (for detailed information about drug tiers refer to the Benefit Schedule).
- Up to a 90 day supply at a Cigna's Home Delivery Pharmacy for drug tiers 1 through 4 and up to a 90 day supply of tier 5 Drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers refer to the Benefit Schedule).
- 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 or precertification.
- 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.

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. 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 http://www.cigna.com/ifp-drug-list. 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 Copayment, Coinsurance or Deductible shown in the Benefit Schedule at the time of purchase. The Member does not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a Cigna's Home Delivery Pharmacy Program, see the home delivery brochure on www.mycigna.com, or contact member services at the number on Your ID card.

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 home delivery Pharmacy claims:
Cigna Home Delivery Pharmacy
P.O. Box 1019
Horsham PA 19044-1019
1-800-835-3784

BENEFIT EXCLUSIONS AND LIMITATIONS

Exclusions

Any services which are not described as covered in the Benefit Schedule, Covered 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 that has not been provided by, or provided by Referral from, Your PCP or has not been authorized by Your PCP or the Cigna Medical Director, except for immediate treatment of an Emergency Medical Condition.
2. Services received before the Effective Date of coverage.
3. Services received after coverage under this EOC ends.
4. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
   - Yourself or Your employer;
   - a person who lives in the Member's home, or that person's employer;
   - a person who is related to the Member by blood, marriage or adoption, or that person's employer.
   - A facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which you receive, directly or indirectly, remuneration.
5. Care for health conditions that are required by state or local law to be treated in a public facility.
6. Care required by state or federal law to be supplied by a public schools system or school district.
7. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
8. Treatment of an Illness or Injury which is due to war, declared or undeclared.
9. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this EOC.
10. Services of a Hospital emergency room for any condition that is not an Emergency Medical Condition as defined by this EOC.
11. 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.
12. Any services and supplies for or in connection with Experimental, Investigational or Unproven Procedures. Experimental, Investigational or Unproven Procedures do not include routine patient care costs related to qualified clinical trials as described in your EOC document.
13. Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance (except as provided in the definition of Reconstructive Surgery or the description of the Reconstructive Surgery benefit in this EOC); Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy. Cosmetic surgery or therapy is defined as

surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.

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

- macromastia or gynecomastia surgeries;
- Surgical treatment of varicose veins;
- abdominoplasty;
- panniculectomy;
- rhinoplasty;
- blepharoplasty;
- redundant skin surgery;
- removal of skin tags;
- acupressure;
- craniosacral/cranial therapy;
- dance therapy, movement therapy;
- applied kinesiology;
- rolfing;
- prolotherapy; and
- extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

14. 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. Any medical and surgical services for the treatment or control of obesity that are not included under the "Covered Services and Benefits" section of this EOC;
15. Unless otherwise covered under "Covered Services and Benefits," 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 specifically covered under "Covered Services and Benefits."
17. Reversal of male and female voluntary sterilization procedures.
18. Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex unless such services are deemed Medically Necessary or otherwise meet applicable coverage requirements.

19. Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire.

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. Charges for animal to human organ transplants.

22. Non-medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety and services, training, except otherwise specifically covered in this EOC.

23. 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.

24. Complementary and alternative medicine services, including but not limited to: 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

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

26. 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) and as specifically provided or arranged by Cigna.

27. 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 “Covered Services and Benefits” section. Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, Durable Medical Equipment items that are not covered, include but are not limited to those listed below:

    - Hygienic or self-help items or equipment;
    - Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
    - Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
    - Institutional equipment, such as air fluidized beds and diathermy machines;
    - Elastic stockings and wigs;

- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and Splints;
- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
- Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
- Hearing aid batteries (except those for cochlear implants) and chargers.

28. Private hospital rooms and/or private duty nursing except as provided in the “Home Health Services” or “Hospice Services” section of “Covered Services and Benefits.”, or when deemed medically appropriate by Us.
29. 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.
30. Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
31. 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 “Covered Services and Benefits” section of the EOC.
32. 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.
33. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery and pediatric vision).
34. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
35. Treatment by acupuncture.
36. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, Experimental, Investigational and Unproven drugs, except as provided in "Covered Services and Benefits.”
37. 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 as part of another Covered Service.
38. Membership costs or fees associated with health clubs and weight loss programs.
39. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
40. Dental implants for any condition.
41. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Cigna Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
42. Blood administration for the purpose of general improvement in physical condition.

43. Cost of biologicals that are immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
44. Cosmetics, dietary supplements and health and beauty aids.
45. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
46. 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).
47. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
48. The following mental health and substance use disorder services are specifically excluded from coverage under this EOC:
    - 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 Mental Health or chemical or alcohol dependency as described in the Mental Health Residential Treatment Services or the

      Substance Use Disorder Residential Treatment provisions);
    - 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.

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 Appeal (For Illinois residents)

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

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

Start with Customer Service

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

Cigna
Individual Services
PO Box 182223
Chattanooga TN 37422

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

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

Appeals Procedure

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

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

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

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

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

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

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

The Member will be notified in writing of the decision within 5 working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

Expedited Appeal

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

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

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

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

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

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

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

(i) reasons for the determination,

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

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

External Independent Review Procedure

External Review Procedure

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

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

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

To request a review, You must send a written request to the Illinois Department of Insurance within 4 months of Your receipt of Cigna's appeal review denial. You or your authorized representative may include all relevant documentation and any additional information with Your appeal request. The Independent Review Organization will render an opinion within 45 days after receiving all necessary information. When requested and when determined a delay would be detrimental to Your condition, the review shall be completed within 72 hours or 5 days for expedited experimental/investigational reviews.

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

Expedited External Review Procedure

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

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

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

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

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

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

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

Ineligible for External Review:

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

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

Ineligible for Expedited External Review:

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

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

Appeal to the State of Illinois

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

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

Toll Free Telephone: (877) 527-9431
Fax: (217) 558-2083
Email: complaints@ins.state.il.us
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided to You, Your designee or guardian, Your Primary Care Physician and the ordering health care Provider, in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific 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; (6) information about any office of health insurance consumer assistance or ombudsman available to assist You in the appeal process; (7) Cigna's address, toll-free phone number, fax number and appeal email address; (8) information that is specific and limited to appeals and external review procedures for Your plan; (9) information about the one level of appeal that is available; (10) the date of the adverse determination and, if applicable, the date of the

final adverse determination; and (11) upon exhaustion of internal appeals by the Member, the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that You have 4 months from the date of the letter to file an external review. A final notice of adverse determination will include a discussion of the decision.

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

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

Relevant Information

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

Legal Action

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

Binding Arbitration

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

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30 day period and the 2 arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to

choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a 3rd arbitrator in accordance with these requirements. In the case of an arbitration, the arbitrator shall not have authority to conduct a Class Action, combine or aggregate similar claims of an entity or person not a party to this EOC, or make an award to any person or entity not a party to this EOC.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. The decision of the arbitrator, or the decision of any 2 arbitrators if there are 3 arbitrators, shall be binding upon both parties conclusive of the controversy in question and enforceable in any court of competent jurisdiction.

No party to this EOC shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this EOC pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this EOC.

RELATION of the EOC to OTHER SOURCES of PAYMENT for HEALTH SERVICES

Workers' Compensation

Benefits under this EOC will 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 and
2. where Cigna does not render services but pays for those services which are within the scope of the "Covered 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.

In addition, it is the Member's obligation to fully cooperate with any attempts by Cigna to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure of the employer to take the steps required by law or regulation in connection with such coverage.

Third Party Liability

You agree to advise Us, in writing, within a reasonable time of Your claim against the third party and to take such action, provide such information and assistance, and execute such documents as We may reasonably require to facilitate enforcement of the claim. You also agree to take no action that may prejudice the rights or interests of Us under this EOC. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice our rights or interests, may be considered to be a material breach by Us and may subject You to legal action.

We may have a right to a lien, to the extent of benefits advanced, upon any recovery that You receive from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this EOC for the treatment of the Illness, disease, Injury or condition for which the third party is liable. We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the Injury, Illness or condition is less than the actual loss suffered by the Member. Note: The coverage under this plan is secondary to any automobile no-fault or similar coverage.

In addition, if a Member incurs expenses for Illness or Injury that occurred due to the negligence of a third party:

- We have the right to reimbursement for all benefits we paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Member, Member's parents, if the Member is a minor, or Member's legal representative as a result of that Illness or Injury; and
- We are assigned the right to recover from the third party, or his or her insurer, to the extent of the

benefits we paid for that Illness or Injury.

- We shall have the right to first reimbursement out of all funds the Member, the Member's parents, if the Member is a minor, or the Member's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Illness or Injury.
- You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

COORDINATION OF BENEFITS

This section describes what this EOC will pay for Covered Expenses that are also covered under one or more other plans. You should file all claims with each plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits in the form of payment or services for:

- An insurance plan issued to an individual/non-group or a group; or a self-insured group health plan providing benefits in the form of reimbursement or services for medical care or treatment/items.
- Governmental benefits as permitted by law, except for Medicaid, Medicare and Medicare supplement policies.
- Medical benefits coverage under any form of group or individual automobile insurance.

Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Primary Plan
The plan that pays first as determined by the order of benefit determination rules below.

Secondary Plan
The plan that pays after the primary plan as determined by the order of benefit determination rules below. The benefits under the secondary plan are reduced based on the benefits under the primary plan.

Allowable Expense
The portion of a Covered Expense used in determining the benefits this plan pays when it is the secondary plan. The allowable expense is the lesser of:

- the charge used by the primary plan in determining the benefits it pays;
- the charge that would be used by this plan in determining the benefits it would pay if it were the primary plan, and
- the amount of the Covered Expense.

If the benefits for a Covered Expense under your primary plan are reduced because you did not comply with the primary plan's requirements (for example, getting pre-certification of hospital admission or a second surgical opinion), the amount of the allowable expense is reduced by the amount of the reduction.

Claim Determination Period

A Calendar Year, but does not include any part of a year during which you are not covered under this plan or any date before this section or any similar provision takes effect.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one that applies:

- The plan that covers you as an enrollee or an employee shall be the primary plan and the plan that covers you as a Dependent shall be the secondary plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the primary plan shall be the plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child;
  - then, the plan of the parent not having custody of the child, and
  - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's Dependent) shall be the primary plan and the plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The plan that covers you under a right of continuation which is provided by federal or state law shall be the secondary plan and the plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that covers you is issued out of the state whose laws govern this plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits Payable

- If this plan is the primary plan, the amount this plan pays for a Covered Expense will be determined without regard for the benefits payable under any other plan.
- If this plan is the secondary plan, the amount this plan pays for a Covered Expense is the allowable expense less the amount paid by the primary plan during a claim determination period.

If while covered under this plan, you are also covered by another Cigna individual or group plan, you will be entitled to the benefits of only one plan. You may choose this plan or the plan under which you will be covered. Cigna will then refund any premium received under the other plan covering the time period both policies were in effect. However, any claim payments made by Cigna under the plan you elected to cancel will be deducted from any such refund of premium.

Recovery of Excess Benefits

If this EOC is the secondary plan and Cigna pays for Covered Expenses that should have been paid by the primary plan, or if Cigna pays any amount in excess of what it is obligated to pay, Cigna will have the right to recover the actual overpayment made. Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent of or notice to You, may obtain information from and release information to any other plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide us with any information we request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Benefits

If a Member is eligible for Medicare, Cigna will calculate the claim payment for Covered Services according to the benefit levels of this EOC based on the allowed amount defined below, and pay this amount minus any amount paid by Medicare. Cigna will estimate the amount Medicare would have paid and reduce benefits by this amount for any Member who is eligible to enroll in Medicare but is not enrolled. In no event will the amount paid exceed the amount that Cigna would have paid if it were the sole insurance carrier.

Under this scenario, the allowed amount will be the lesser of:

- The amount Medicare allowed or
- Cigna’s Negotiated Rate for a Participating Provider or
- Cigna's Maximum Reimbursable Charge for a Non Participating Provider.

AMENDMENT OR MODIFICATION OF EOC

Amendment or Modification by Law or Regulation

The provisions of the EOC are subject to the approval of all regulatory bodies of competent jurisdiction, 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 that 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.

Modification in the Event of Invalidation of the Patient Protection and Affordable Care Act

Cigna reserves the rights to (i) change the rates chargeable under the EOC and (ii) amend the terms of this EOC to eliminate, alter, or modify provisions required only by the Patient Protection and Affordable Care Act (P.L. 111-148) in the event of either (a) entry of a final judgment by a court declaring all or part of the law invalid, unconstitutional, or otherwise ineffective or (b) amendments to the law by legislation.

Uniform Modification of Coverage

The provisions of this EOC may be modified to reflect product revisions which have uniformly been made to this plan and to all Members enrolled in this 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 modify this EOC only 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 Premiums following such notice will indicate acceptance of the change.

In any case where Cigna elects to uniformly modify coverage, uniformly terminate coverage or discontinue coverage in a Marketplace, We must provide notice to the Illinois Department of Insurance prior to notifying plan Members. Notice must be sent by certified mail to the Department of Insurance 90 days in advance of when any notification of Our actions is sent to plan Members. This notice must include:

1. a complete description of the action to be taken,
2. a specific description of the type of coverage affected,
3. the total number of covered lives affected,
4. a sample draft of all letters being sent to the plan sponsors, participants, beneficiaries, or covered individuals,
5. time frames for the actions being taken,
6. options the plans sponsors, participants, beneficiaries, or covered individuals may have available to them under this Act, and
7. any other information as required by the Department.

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;

- Weight Loss Programs;
- Wellness Classes (selected classes may be offered to Our Members for a copayment at participating Cigna Health Care Centers); and
- Cigna HealthCare Healthy Babies Program®

These programs are provided for the benefit of 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.

Termination of Coverage

We, without cause, may terminate this EOC upon either: (i) ninety (90) days prior written notice to the Member of our decision to discontinue offering this particular type of coverage; or (ii) one hundred eighty (180) days prior written notice to the Member of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Member may purchase a type of coverage currently being offered in that market

Cancellation

We may cancel this EOC 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 day grace period.
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 EOC or coverage.
5. Material violation of the terms of the EOC
6. When We cease to offer EOC's of this type to all individuals in Your class. In this event, IL 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.
7. When We cease offering any plans in the individual market in IL, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
8. When the Member no longer lives in the Service Area. This does not apply to a dependent child living outside of the Service Area.
9. In the event of entry of a final judgment by a court declaring all or part of the Patient Protection and Affordable Care Act (P.L. 111-148) invalid, unconstitutional, or otherwise ineffective and the State not providing alternative and sufficient means of funding advanced-premium tax credits, this EOC shall be subject to cancellation consistent with applicable federal and state law.

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, 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. There is a $45 fee for reinstatement.

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 ”Notice” 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.

Fraud

If the Subscriber or Dependent has committed, or allowed someone else to commit, any fraud or deception in connection with this EOC, then any and all coverage under this EOC shall be void and of no legal force or effect. For purposes of this provision, fraud and/or deception includes, in addition to other intentional misrepresentation, the concealment or misrepresentation of the direct or indirect source of Your Premium or other cost-sharing obligations under this EOC.

Entire EOC

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

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.

Clerical Error

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

Administrative Policies Relating to This EOC

Cigna may adopt reasonable policies, procedures, rules and interpretations which promote orderly administration of this EOC.

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, each Member authorizes any Provider rendering service to disclose all facts pertaining to such service, to render reports pertaining to such services or the Member's physical condition and to 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.

Class Action Waiver

Except as provided by IL, under this provision of this EOC, You (including any legal representative acting on Your behalf) expressly waive the right to participate, as a plaintiff or class member, in any purported class, collective, representative, multiple plaintiff or similar proceeding ("Class Action"). Except as provided by IL; under this provision of the EOC You expressly waive the ability to maintain a Class Action in any forum.

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 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.

BENEFIT SCHEDULE

The following is the Benefit Schedule, including medical, prescription drugs and pediatric vision benefits. The EOC sets forth, in more detail, the rights and obligations of both You and Your Family Member(s) and the EOC. It is, therefore, important that all Members **READ THE ENTIRE EOC 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 Benefit Schedule, subject to payment of Copayments, Percentage Copayment and any applicable Deductible as specified in the Benefit Schedule, and subject to the conditions, limitations and exclusions of this EOC.

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 EOC.

BENEFIT INFORMATION **Note:** **Covered Services are subject to applicable Deductible unless specifically waived.**	**IN-NETWORK PROVIDER** **(Based on the Negotiated Rate for Covered Expenses)** **YOU PAY:**
Medical Benefits	
Deductible **Individual** **Family**	 $3,400 $6,800 Service-specific Deductible amounts are displayed with the service (e.g. Inpatient Hospital Admission) in the Benefit Schedule.
Out-of-Pocket Maximum **Individual** **Family**	 $7,900 $15,800 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Coinsurance	You and Your Family Members pay 30% of Charges after the 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 EOC. 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-Periodic Health Examinations" section of the EOC for additional details.	0%, Deductible waived
Newborn/Infant Hearing Screening	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Pediatric Vision Care See the "Covered Benefits" section for details Performed by an Ophthalmologist or Optometrist for a Member, 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 benefits.	
Comprehensive Eye Exam Limited to one exam per year	0% per exam, Deductible waived
Pediatric Frames for Children Limited to one pair per year	0% per pair, Deductible waived
Eyeglass Lenses for Children Limited to one pair per year	0% per pair, Deductible waived
Contact Lenses for Children	
Elective 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 professional services.	0% per pair, Deductible waived
Therapeutic Covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses.	0% per pair, Deductible waived
Note: Routine vision screening performed by a PCP or pediatrician is covered under the Preventive Services benefit	
Physician Services	
Office Visit **Primary Care Physician (PCP)**	$15 Copayment, Deductible waived
Specialist Physician (including consultant and referral services)	30%
NOTE: if a Copayment applies for OB/GYN visits, the level of Copayment You pay will depend on how Your doctor is listed in the provider directory	

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
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 EOC Prescription Drug benefits, limitations and exclusions. **Covered Services from any other Participating Physician delivered by Virtual means** (Not limited to minor acute medical conditions)	$15 Copayment, Deductible waived Same Cost Share as if service was delivered in person.
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**	30% 30% 30% 30% 30%
Indian Health Program / Tribal Health Program Services* Any Covered Services provided by an Indian Health Program or Tribal Health Program Note: these benefits apply only to a Member who is either a member of a federally-recognized Native American tribe or an Alaska native. *** see the Definitions section in the EOC for additional information on "Indian Health Program" and the "Tribal Health Program.**	0%
Second Surgical Opinion	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Hospital Services **Inpatient Hospital Services** Facility Charges	30%
Professional Charges	30%
Emergency Admissions	Benefits are shown in the Emergency Services Schedule
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	30%
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services **Facility and interpretation charges**	
Physician's Office	30%
Free-standing/Independent lab or x-ray facility	30%
Outpatient hospital lab or x-ray	30%
MRIs, MRAs, CAT Scans, PET Scans	30%
Short-Term Rehabilitative Services Physical, Occupational and Speech Therapy	30%
Naprapathic Services Maximum of 15 visits per Member, per Calendar Year	30%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Member, within a six month period	30%
Chiropractic Services Maximum of 25 visits per Member, per Calendar Year	30%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Habilitative Services	30%
Hearing Aids For children up to age 19, 1 per ear every 36 months	30%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	30%
Family Planning	
Womens' Contraceptive Services and Sterilization	0%, Deductible waived
Male Sterilization	30%
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)	30%
Hospital Delivery charges	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	30%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	30%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
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 EOC for specific details and limitations.	PCP or Specialist Office Visit benefit applies 30% Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities	30%
Home Health Services	30%
External Prosthetic Appliances	30%
Durable Medical Equipment	30%
Hospice **Inpatient** **Outpatient**	Inpatient Hospital Services benefit applies 30%
Mental, Emotional, Functional Nervous Disorders and Serious Mental Illness **Inpatient** (Includes Acute and Residential Treatment) **Outpatient** (Includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services	Inpatient Hospital Services benefit applies 30% 30%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
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 30% 30%
Organ and Tissue Transplants- (Note: Ventricular assist devices and advanced cellular therapy are **only** covered at a LifeSOURCE facility. See benefit detail in "Covered Services and Benefits" section for covered procedures and other benefit limits which may apply.) **Cigna LifeSOURCE Transplant Network® Facility** **LifeSOURCE Transplant Network® Facility Travel Maximum**: $10,000 per Member, per transplant **Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services** **Participating Facility NOT specifically contracted to perform Transplant Services or Out-of-Network Facility**	0% 30% NOT COVERED
Advanced Cellular Therapy Services Cigna LifeSOURCE Transplant Network® Facility Non-LifeSOURCE Facility (Participating or Non-Participating)	0% Not Covered

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Ventricular Assist Device Services Cigna LifeSOURCE Transplant Network® Facility Non-LifeSOURCE Facility (Participating or Non-Participating)	0% Not Covered
Infertility **(see "Covered Benefits" section for specific information about what services are covered and benefit limits which may apply)**	30%
Bariatric Surgery	Benefit depends on type of service provided
Infusion and Injectable Specialty Prescription Medications and related services or supplies	30%

Emergency Services ***(Note: This EOC covers Emergency Services from Participating and Non-Participating Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Negotiated Rate for Covered Expenses	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge for Covered Expenses **Please Note:** With respect to the Cost Sharing amounts shown below, 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. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider. You are also responsible for: all charges that are not Covered Expenses under this EOC.
Emergency Services		
• **Hospital Emergency Room**		
Emergency Medical Condition	30%	In-Network Cost Share
Non-Emergency Medical Condition	Not Covered	Not Covered
• **Urgent Care Services**		
Emergency Medical Condition	$35 Copayment per visit, Deductible waived	In-Network Cost Share
Non-Emergency Medical Condition	$35 Copayment per visit, Deductible waived	Not Covered
• **Ambulance Services** Note: coverage for Medically Necessary transport to the nearest facility capable of handling an Emergency Medical Condition.		
Emergency Transport	30%	In-Network Cost Share
• **Treatment of Sexual Assault Victims**	0%	In-Network Cost Share

Emergency Services ***(Note: This EOC covers Emergency Services from Participating and Non-Participating Providers as shown:***	***What You Pay*** For **Participating Providers** based on the Negotiated Rate for Covered Expenses	***What You Pay*** For **Non-Participating Providers** based on the Maximum Reimbursable Charge for Covered Expenses **Please Note:** With respect to the Cost Sharing amounts shown below, 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. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider. You are also responsible for: all charges that are not Covered Expenses under this EOC.
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
• **Hospital Facility Charges** Emergency Services from a Non-Participating Provider are covered at the Participating Provider Cost Share until the patient is transferrable to a Participating facility. Non-Participating facility benefits are not covered once the patient can be transferred, whether or not the transfer takes place.	30%	In-Network Cost Share until transferable to an In-Network Hospital
• **Professional Services** Emergency Services from a Non-Participating Provider are covered at the Participating Provider Cost Share until the patient is transferrable to a Participating facility. Benefits for Non-Participating Provider Professional Services are not covered once the patient can be transferred, whether or not the transfer takes place.	30%	In-Network Cost Share until transferable to an In-Network Hospital

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	

Note:
You can obtain a 30-day supply of any Prescription Drug or refill at any Participating Retail Pharmacy.

You can obtain up to a 90-day supply of Your Prescription Drug or refill at either a 90-day Retail Pharmacy or through the Cigna Home Delivery Pharmacy.

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

Prescription Drug Deductible	Deductible applies to Prescription Drugs	
	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Cigna Home Delivery Pharmacy Drug Program** **YOU PAY PER PRESCRIPTION OR REFILL:**
Tier 1: This tier typically includes preferred Generic Drugs. These drugs have the same strength, and active ingredients as Brand Name Drugs, but often cost much less. Preferred Generic Drugs are covered at the plan's lowest Cost Share.	$8 Copayment per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply.	$24 Copayment per Prescription or refill, Deductible waived Up to a 90 day maximum supply
Tier 2: This tier typically includes most Generic Drugs and some low cost Brand Name Drugs. Generic Drugs have the same strength and active ingredients as Brand Name Drugs, but often cost much less.	$25 Copayment per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day supply.	$75 Copayment per Prescription or refill, Deductible waived Up to a 90 day maximum supply
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	$60 Copayment after Deductible per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy. You pay a Copayment for each 30 day Pharmacy.	$180 Copayment per Prescription or refill, Deductible waived 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
Tier 4: This tier typically includes non-preferred Brand Name Drugs and some high cost Generic Drugs.	50% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy.	50% per Prescription or refill Up to a 90 day maximum supply
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	30% per Prescription or refill 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy.	30% per Prescription or refill Up to a 90 day maximum supply
Preventive Drugs regardless of Tier Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive including but not limited to: : ▪ women's contraceptives that are Prescribed by a Physician and Generic or Brand Name with no Generic alternative; and ▪ up to a 12-month supply of contraceptives (including over-the-counter), and products, will be covered when dispensed or furnished at one time; and ▪ smoking cessation products, limited to a maximum of two 90-day regimens.	0% per Prescription or refill, Deductible waived 30 day supply at any Participating Pharmacy or Up to a 90 day supply at a 90 Day Retail Pharmacy.	0% per Prescription or refill, Deductible waived Up to a 90 day maximum supply