Cigna HealthCare of North Carolina, Inc.

INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE
Cigna Connect 150-4

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

THIS IS A LEGAL CONTRACT
Read Your Evidence Of Coverage Carefully

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

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

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

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

Signed for Cigna by:

Julia M. Huggins, President

Anna Krishtul, Corporate Secretary

IMPORTANT NOTICE

Direct Access to Obstetricians and Gynecologists (OB/GYN)

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

Selection of a Primary Care Provider

This 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.

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.

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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, FOSTER OR, ADOPTED CHILDREN OF THE SUBSCRIBER ADDED WITHIN 60DAYS AFTER BIRTH OR PLACEMENT IN YOUR HOME), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED, OMITTED OR THAT YOU OR YOUR DEPENDENT(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT (S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE.

IF WE RESCIND YOUR COVERAGE, WE WILL PROVIDE YOU WITH 30 DAYS ADVANCE NOTICE AND WE WILL REFUND ALL PREMIUMS YOU PAID FOR YOUR EOC LESS THE AMOUNT OF ANY CLAIMS PAID BY CIGNA. RESCISSION OF YOUR COVERAGE WILL RESULT IN DENIAL OF ALL PENDING CLAIMS AND, IF CLAIM PAYMENTS EXCEEDS TOTAL PREMIUM PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE. PLEASE NOTE RESCISSION OF COVERAGE IS SUBJECT TO THE INTERNAL APPEALS PROCESS

RIGHT TO RETURN CONTRACT

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

ROLE OF THE PRIMARY CARE PHYSICIAN

Establishment of the Physician-Patient Relationship

By enrolling, You are choosing to have services and benefits under the "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

A Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Member. For this reason, when you enroll as a Member, you will be asked to select a Primary Care Physician ("PCP"). Your PCP will provide your regular medical care and assist in coordinating your care. You may select your PCP by calling the customer service phone number on Your ID card or by visiting Our website at www.mycigna.com. The Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of Your Dependent(s). You have the right to designate any Primary Care Physician who participates in Our network and is available to accept You or Your Dependent(s). If you do not choose a PCP, We will select a PCP for you.

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

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

Cigna will not limit either of the following:

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

Changing Primary Care Physicians

You may voluntarily change Your PCP but not more than once in any calendar month. We reserve the right to determine the number of times during a plan Year that You will be allowed to change Your PCP. You may request a change from one Primary Care Physician to another by going to mycigna.com, clicking on 'Manage My Health Team', click "Additional info on PCP selection", and follow the directions displayed; or by contacting Us at the Customer Service number on Your ID card. 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 30 days in advance of the date the PCP leaves the network and provide assistance in selecting a new PCP or identifying a new In-Network specialist to continue providing Covered Services. If you do not choose a PCP after being notified that Your PCP is no longer a Participating Physician We will select a PCP for you. If You are receiving treatment from a Participating Provider at the time his or her Participating Provider agreement is terminated, for reasons other than medical incompetence or professional misconduct, You may be eligible for continued care with that Provider.

Continuity of Care

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

Such continuity of care must be approved in advance by Cigna, and Your doctor must agree to accept Our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider who ceases to be a Participating Provider will not be available, such as when the Provider loses his/her license to practice or retires.

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

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

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

Confined to a Hospital

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

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

Referrals to Specialists

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

Exceptions to the Referral process:

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

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

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

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

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

Standing Referral to Specialist

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

1. You are a covered Member of the Cigna HMO EOC;
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. If You receive a standing Referral or any other Referral from Your PCP, that Referral remains in effect even if the PCP leaves the Cigna's network. If the treating specialist leaves Cigna's network or You cease to be a covered Member, the standing Referral expires.

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.

- **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 Benefit 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 – Network Exception**
  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 those services are unavailable from a Participating Provider, when a Participating Provider cannot provide timely Covered Services, or
  - for any other reason We determine it is in Your best interests to receive services from a Non-Participating Provider.

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

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

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, Coinsurance and any applicable Deductible as specified in the Benefit Schedule, and subject to the conditions, limitations and exclusions of this EOC.

1. 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.
2. 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 **NOTE:** Treatment in regard to the following will be covered at the plan level for the specific service. **The following benefits are covered as mandated by North Carolina:** Lymphedema, emergency care, minimum inpatient stay following delivery of a baby, minimum benefits offered for alcoholism/drug abuse treatment, access to non-formulary drugs, hearing aids, bone mass measurement, contraceptives or devices, colorectal cancer screening, newborn hearing screening, ovarian cancer surveillance tests, prostate cancer screening, reconstructive breast surgery following a mastectomy, coverage for congenital defects and anomalies, clinical trials, anesthesia and hospital charges for dental procedures for certain individuals, diabetes, mental illness equity in benefits and minimum coverage requirement, coverage for certain off-label drug use for the treatment of cancer, TMJ dysfunction coverage, cardiac and pulmonary rehabilitation, orthotic device for positional plagiocephaly, organ donor search, sexual dysfunction, sterilization, blood services.	
Deductible **Individual** **Family** Note: Additional Deductibles may apply to specific benefits.	 $150 $300
Coinsurance	You and Your Family Members pay 10% of Charges after the Annual Deductible.

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:
Out-of-Pocket Maximum **Individual** **Family**	 $900 $1,800 The following do not accumulate to the In-Network Out of Pocket Maximum: Penalties and Policy Maximums.
Prior Authorization Program **Prior Authorization – Inpatient Services** **Prior Authorization – Outpatient Services** **NOTE:** Please refer to the section on Prior Authorization of inpatient and outpatient services above for more information in Your Plan. You can obtain a complete list of admissions, services and procedures that require Prior Authorization by calling Cigna at the number on the back of Your ID card or at www.mycigna.com under "View Medical Benefits Details".	 Your Participating Provider must obtain approval for inpatient admissions; or Your Provider may be assessed a penalty for non-compliance. Your Participating Provider must obtain approval for certain outpatient procedures and services; or Your Provider may be assessed a penalty for non-compliance.
Preventive Care Services Please refer to "Preventive Care Services-Periodic Health Examinations" section of the Plan for additional details.	0%, Deductible waived
Newborn/Infant Hearing Screening	0%, Deductible waived

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

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	IN-NETWORK PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY:
Physician Services	
Office Visit	
Primary Care Physician (PCP)	$0 Copayment, Deductible waived
Specialist Physician (including consultant, referral and second opinion services)	10%
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	
Physician Services, continued	
Surgery in Physician's office	10%
Outpatient Professional Fees for Surgery (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	10%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	10%
In-hospital visits	10%
Allergy testing and treatment/injections	10%
Cigna Telehealth Connection Services	
▪ Virtual visit with a **Cigna Connection Physician** Limited to minor acute medical conditions Note: if a Cigna Telehealth Connection Physician issues a Prescription, that Prescription is subject to all Plan Prescription Drug benefits, limitations and exclusions.	$0 Copayment, Deductible waived
▪ **Covered Services from any other Participating Physician delivered by Virtual means** (Not limited to minor acute medical conditions)	Same benefit as when service provided in person

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 Professional Charges **Emergency Admissions**	 10% 10% Benefits are shown in the Emergency Services Schedule.
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	10%
Laboratory, Diagnostic Therapeutic Radiology and Advanced Imaging Services **Facility and interpretation charges** Physician's Office Free-standing/Independent lab or x-ray facility Outpatient hospital lab or x-ray MRIs, MRAs, CAT Scans, PET Scans	 10% 10% 10% 10%
Rehabilitative Services Maximums do not apply to services for treatment of Autism Spectrum Disorders **Physical Therapy and Occupational Therapy and Chiropractic Treatment** Combined limit of 30 visits per Member, per Calendar Year **Speech Therapy** Limit of 30 visits per Member, per Calendar Year	10%

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:
Cardiac & Pulmonary Rehabilitation Note: Cardiac Rehabilitation, maximum of 30 visits per Member per Calendar Year. Limits based on Medical Necessity guidelines. Note: Pulmonary Rehabilitation, maximum benefit of 1 course per Member per Calendar Year.	10%
Habilitative Services Maximum of 30 visits per Member per Calendar Year	10%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD), and Other Disorders Related to the Bones or Joints of the Jaw, Face or Head	10%
Women's Contraceptive Services Family Planning and Sterilization	$0 Copayment, Deductible waived
Male Sterilization	10%
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)	10%
Hospital Delivery charges	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	10%
Postnatal visit or treatment billed separately from "global" fee	PCP or Specialist Office visit benefit applies
Infertility	10%
Sexual Dysfunction	10%

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:
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office visit benefit applies
Diagnostic testing	10%
Treatment of Autism Spectrum Disorder Please refer to "Autism Spectrum Disorder" section of the Plan for specific details and limitations.	Copay or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Member, per Calendar Year for all facilities listed.	10%
Home Health Services Maximum: Unlimited days per Member	10%
External Prosthetic Appliances	10%
Durable Medical Equipment	10%
Orthotic Devices for Positional Plagiocephaly	10%
Hearing Aids Limited to one hearing aid per each hearing-impaired ear every 36 months.	10%
Diagnosis and Treatment of Lymphedema	10%

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:
Coverage of Clinical Trials	10%
Hospice	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	10%
Mental, Emotional Health	
Inpatient (Includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	10%
All other outpatient services	10%
Substance Use Disorder	
Inpatient Detoxification/Rehabilitation (Includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (Includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	10%
All other outpatient services	10%
Smoking Cessation **Medical treatment** **Maximum of 2 courses of treatment per Year** **(Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit)**	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:
Bariatric Surgery **(See benefit detail in the section titled "Covered Services And Benefits" for covered procedures and other benefit limits which may apply.)**	10%
Organ and Tissue Transplants (Note: Ventricular assist devices are **only** covered at a LifeSOURCE facility. See benefit detail in "Covered Services and Benefits" for covered procedures and other benefit limits which may apply.) **Cigna LifeSOURCE Transplant Network® Facility** **Travel Benefit,** (Only available through Cigna **LifeSOURCE** Transplant Network ® Facility) **Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services** **Participating Facility NOT specifically contracted to perform Transplant Services**	 0% 10% Not covered
Ventricular Assist Device Services Cigna LifeSOURCE Transplant Network® Facility Non-LifeSOURCE Facility (Participating or Non-Participating)	 0% Not covered
Infusion and Injectable Medications and related services or supplies administered by a medical professional in an office or outpatient facility	10%
Dental Care (other than Pediatric) **Limited to treatment for accidental injury to natural teeth.**	10%

Emergency Services **This EOC covers Emergency Services from Participating and Non-Participating Providers; Covered Services are subject to Deductible unless specifically waived.**	***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: In addition to the cost-sharing amounts described below, you may be responsible for additional charges including but not limited to (a) charges for non-Covered Services and (b) charges for services performed that are in excess of the Maximum Reimbursable Charge.	
Emergency Services • **Hospital Emergency Room** **Emergency Medical Condition** **Non-Emergency Medical Condition** • **Urgent Care Services** • **Ambulance Services** Note: coverage for Medically Necessary transport to the nearest facility capable of handling the Emergency Medical Condition. **Emergency Transport**	 $200 Copayment, waived if admitted per visit Not Covered $25 Copayment, Deductible waived 10%	 In-network Cost Share for an Emergency Medical Condition, otherwise You pay 100% Not Covered. You pay 100% of charges In-network Cost Share for an Emergency Medical Condition, otherwise You pay 100% In-network Cost Share for an Emergency Medical Condition, otherwise You pay 100%
Inpatient Hospital Services (for emergency admission to an acute care Hospital) • **Hospital Facility Charges** • **Professional Services**	 10% 10%	 In-Network Cost Share until transferable to an In-Network Hospital; if not transferred then You pay 100% In-Network Cost Share until transferable to an In-Network Hospital; if not transferred then You pay 100%

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY	EXPRESS SCRIPTS PHARMACY, Cigna's 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 covered Prescription Drug or Related Supply at any Participating Retail Pharmacy.** **You can obtain up to a 90 day supply of any covered Prescription Drug or Related Supply at either a 90 day Retail Pharmacy or through the Express Scripts 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	Integrated medical and Prescription Drug Deductible	
	Cigna Retail Pharmacy Drug Program **YOU PAY PER PRESCRIPTION OR REFILL:**	**Express Scripts Pharmacy Cigna's home delivery Pharmacy** **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.	$0 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.	$0 Copayment per Prescription or refill. Deductible waived. 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	$10 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	$30 Copayment per Prescription or refill. Deductible waived. 90 day maximum supply

PRESCRIPTION DRUG BENEFIT INFORMATION	RETAIL PHARMACY YOU PAY AMOUNTS SHOWN ARE YOUR RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN SATISFIED	EXPRESS SCRIPTS PHARMACY, Cigna's HOME DELIVERY PHARMACY YOU PAY
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	$30 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	$90 Copayment per Prescription or refill. Deductible waived. 90 day maximum supply
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 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 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 ▪ smoking cessation products, limited to a maximum of two 90 day regimens.	0%, Deductible waived per Prescription or refill 30 day supply - at any Participating Pharmacy or Up to a 90 day supply at a 90-Day Retail Pharmacy.	0%, Deductible waived per Prescription or refill 90 day maximum supply

DEFINITIONS

90 day Retail Pharmacy is a Participating Retail Pharmacy that provides all the Covered Services of any other Participating Retail Pharmacy, and also, through an agreement with Cigna, or with an organization contracting on Cigna's behalf, dispenses up to a 90 Day supply of Prescription Drugs and Related Supplies. 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. an independent private entity that: (i) is organized as a not-for-profit organization under State law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on Your behalf solely on the basis of publically available criteria and does not in any way consider the health status of any Member in determining whether to make such payments on Your behalf.

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

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

Autism Spectrum Disorders means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger's Syndrome, and 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 Drug (Brand Name) means a Prescription Drug that Cigna identifies as a Brand Drug across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or biologics as either Brand or Generic based on a number of factors. Not all products identified as a "Brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the EOC.

Business Decision Team is a committee comprised of voting and non-voting representatives across various business of Cigna or its affiliate 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 directly or indirectly with Cigna for a different amount, including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

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

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

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

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

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

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

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

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

Copayment/Copay 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 the expenses incurred for Covered Services which 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.

As determined by Cigna, Covered Expenses will include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with Providers for the provision of any Covered Services.

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. Covered Expenses may be less than the amount that is actually billed.

Covered Services are Medically Necessary services or supplies that:

a. are listed in the benefit sections of this 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.

Creditable Coverage is coverage under any of the following:

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

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

Custodial Services include, but are not limited to:

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

Days means calendar days unless expressly stated otherwise.

Deductible means the amount of Covered Expenses each Member must pay 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; to include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices in the injection of insulin and any other required disposable supplies. Podiatric appliances for the prevention of complications associated with diabetes. The repair or maintenance of insulin pumps not covered under a manufacturer's warranty and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

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

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

Durable Medical Equipment is defined as items which:

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

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

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

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

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

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

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

Essential Health Benefits means, to the extent covered under this EOC, expenses incurred with respect to Covered Services, in at least the following categories: ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, Mental Health and Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and Habilitative Services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Evidence of Coverage (EOC) means the Cigna HealthCare of North Carolina, Inc. Individual plan Evidence of Coverage document, the 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 / Unproven Procedures: a drug, device or medical treatment or procedure is considered Experimental or Investigational or Unproven if:

- it has not been demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or evaluating the condition or illness for which it is proposed; or
- it has not been given approval for marketing by the United States Food & Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the current standard of treatment or diagnosis; 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 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 Deductible applies if You have a family plan and You and one or more of your Family Member(s) are Insured under this EOC. It is an accumulation of the Individual Deductible paid by each Family Member for Covered Expenses for medical and Prescription Drug Covered Services during a Year. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. Once the Family Deductible amount is satisfied in a year, any remaining Individual Deductibles will be waived for the remainder of the Year. The amount of the Family Deductible is described in the Benefit Schedule.

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

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

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

Generic Drug (or **Generic**) means Prescription Drug that Cigna identifies as a Generic Drug at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or biologics (including biosimilars) as either Brand or Generic based on a number of factors. Not all products identified as a "Generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the EOC.

Habilitative Services are those services that are:

- designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,
- cover health care services and devices that help a member keep, learn, or improve skills and functioning for daily living (Habilitative Services).
- expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time,
- individualized and there is a documentation outlining quantifiable, measurable and attainable treatment goals.

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

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

Hospice Care Services means palliative and supportive medical, nursing, and other health services through home or inpatient care that are Covered Expenses 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, 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.

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

Indian Health Program is only applicable to a Member who is a Native American or Alaska Native, and is defined as follows:

- 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 In-Network 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 Expenses, You will no longer have to pay any Coinsurance or Copayment for medical or Prescription Drug 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.

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

Infusion and Injectable Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional. These medications include but are not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. Such specialty medications may require Prior Authorization or Step Therapy. Refer to the "Prescription Drug Benefits" section of this EOC for Prior Authorization and Step Therapy information.

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 following, not to exceed the Non-Participating Provider's billed Charges:
    - 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.
- **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 "Services and Benefits" Section.

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

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not primarily for the convenience of the Member, the Member's family, Physician or another Provider.
- For Medically Necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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

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

Mental Health or Substance Use Disorder Residential Treatment Center means an institution which:

- specializes in the treatment of psychological and social disturbances that are the result of Mental Health and/or Substance Use Disorder conditions;
- provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians, other licensed healthcare professional under the direct supervision of a physician, or a healthcare professional independently licensed by a state to provide such services and working within the scope of his/her license (Physician Assistant, Nurse Practitioner);
- provides 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.

Mental Health Services is defined as a disorder that impairs the behavior, emotional reaction or thought processes; these include, but are not limited to: depression, psychosis, mania or other psychological symptoms.

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

Network Specialist means a specialty practice Physician who is part of the network for this EOC at the time services are rendered.

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

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

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

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

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

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

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

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

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

Participating (In-Network) Pharmacy means a retail Pharmacy with which Cigna has contracted to provide Prescription Drug services to Members; or the Cigna designated home delivery Pharmacy with which Cigna has contracted to provide home delivery 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, 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; or

For the purposes of reimbursement for Covered Expenses, an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with Providers for the provision of any services and/or supplies, the charges for which are Covered Expenses.

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

Pharmacy is a duly licensed pharmacy that dispenses Prescription Drugs or Related Supplies in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drugs and Related Supplies through mail order.

Pharmacy & Therapeutics (P&T) Committee. means a committee comprised of both voting and non-voting clinicians, 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, for example, 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.

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

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

Prescription Drug means a drug, biologic (including a biosimilar), or other Prescription Drug that has been approved by the U.S. Food and Drug Administration (FDA), certain Prescription Drugs approved under the Drug Efficacy Study Implementation review, or Prescription Drugs marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill. This definition includes Generic Drugs, Brand Name Drugs, and Specialty Medications.

Prescription Drug List means a listing of covered 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 regularly reviewed and updated. You can view the drug list on www.mycigna.com

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.

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

Prior Authorization means the approval for certain medical services or Prescription Drugs and Related Supplies that a Participating Provider must request and receive, from Cigna's Medical Director for medical services and from the Pharmacy and Therapeutics Committee for Prescription Drugs and Related Supplies, before the services are rendered, or the Prescription Drugs are Prescribed, in order for those medical services or Prescription Drugs and Related Supplies to be eligible for benefits under this 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 or
- an entity that directly or indirectly arranges, through contracts with other Providers, for the provision of any Covered Services.

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 or lumpectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

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

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

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

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

Service Area means the area where Cigna has a Participating Provider network for use by this EOC. The counties in the Service Area are Chatham; Johnston; Nash; Orange; and Wake. To locate a Provider who is Participating in the Network used by this EOC, call the toll-free number on the back of Your ID card, or check www.mycigna.com and click on "Find Care and Cost".

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

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

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

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

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

Specialty Medication is a pharmaceutical product, including Self-administered Injectable Medications and Infusion and Injectable Medications considered by Cigna to be a Specialty Medication based on the following factors, subject to applicable law:

- whether the Prescription Drug or pharmaceutical product is prescribed and used for the treatment of complex, chronic or rare conditions, and
- whether the Prescription Drug or pharmaceutical product has a high acquisition cost; and:
- whether the Prescription Drug or pharmaceutical product 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 Prescription Drug benefit or medical 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 medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of Hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including Medically Necessary services and supplies to maintain stabilization until the Member is transferred.

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

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

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. It causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

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

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 an Insured Person 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 means Cigna HealthCare of North Carolina, Inc.

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

ELIGIBILITY

To be eligible for Covered Services You must be enrolled as a Member. To be eligible to enroll as a Member You must meet either the Subscriber or Dependent eligibility criteria listed below.

This EOC is for residents of the state of North Carolina. The Subscriber must notify Us of all changes that may affect any Member's eligibility under this EOC.

Subscriber

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

- Be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- Be a resident of the state of North Carolina; and
- Live within the Enrollment 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:

- Your lawful spouse or domestic partner.
- Your children who have not yet reached age 26.

  Your own, Your spouse's or domestic partner's **Newborn children** are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of birth, and pay any additional premium. Coverage for a newborn dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's birth, or the first date of coverage under this EOC, whichever is later.

  An **adopted child,** including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of adoption, and pay any additional premium. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's placement for adoption or initiation of a suit of adoption, or the first date of coverage under this EOC, whichever is later.

A **foster child** is automatically covered for 31 days from the date of placement in Your residence. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the date of placement in the home, and pay any additional premium. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's placement for foster care, or the first date of coverage under this EOC, whichever is later.

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

If a court has ordered an Insured to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage past that time You must enroll the child as an insured Family Member by applying for his or her enrollment as a dependent within 60 days of the court order date, and paying any additional premium. If no additional premium is required You must enroll the child, but no prior notification is required. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order

- Your stepchildren who have not yet reached age 26.
- Your own, or Your spouse's or domestic partner's children, regardless of age, enrolled prior to age 26, who are incapable of self-support due to medically certified continuing intellectual or physical disability, and are chiefly dependent upon the Insured for support and maintenance. Cigna may require written proof of such disability and dependency within 31 days after the child's 26th birthday.

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 Open Enrollment Period must wait until the next Open Enrollment Period to enroll in a plan or to change plans. However, if a person experiences a triggering event as described below, the triggering event starts a 60-day Special Enrollment Period during which an eligible person can enroll and a Subscriber can add dependents and change coverage. The 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 (QHP), as defined by PPACA, experiences a triggering event.

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

Triggering events for a special enrollment period OFF Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage, (NOTE: special enrollment for marriage only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaskan Native) birth adoption or placement for adoption or through a child support order or other court order; or
- An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to the Subscriber's becoming entitled to Medicare, divorce or legal separation of the covered Subscriber, and death of the covered Subscriber; or
- An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan; or
- An individual who was not previously a citizen, national or lawfully present individual gains such status; or

- An eligible individual's enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent, or erroneous and as the result of the error, misrepresentation, or inaction of an officer, employee or agent of the state Marketplace, or of the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or action; or
- An eligible individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a Qualified Health Plan. The Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; or
- An eligible individual gains access to new Qualified Health Plans as a result of a permanent move (including a move outside the Enrollment Area of the individual's current plan).

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

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

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

For all other triggering events the effective dates are:

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

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage, pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per calendar year), or the qualified individual or dependent is enrolled in any non-calendar year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-calendar year insurance is the last day of the plan or EOC 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, (NOTE: special enrollment for marriage only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaskan Native) 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 individual, or his or her dependent, who has purchased an off-Marketplace plan who experiences a decrease in household income; is newly determined eligible for APTC; and had minimum essential coverage for one or more days during the 60 days preceding the date of the financial change; 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 the 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 Enrollment 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 or an Alaska Native, as defined by section 4 of the Indian Health Care Improvement Act (or their dependent), may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month; or
- An eligible individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the Marketplace may provide; or A qualified individual (or their dependent) who is enrolled in minimum essential coverage and is a victim of domestic abuse or spousal abandonment seeks to enroll in coverage separate from the perpetrator;
- A qualified individual or dependent applies for Marketplace or Medicaid or CHIP coverage during open enrollment or due to a qualifying life event, but is determined ineligible for Medicaid or CHIP after the Exchange open enrollment period has ended or more than 60 days after a qualifying life event;
- The qualified individual or enrollee (or their dependent) adequately demonstrates to the Marketplace that a material error related to plan benefits, Service Area or premium influenced their decision to purchase a QHP; or
- At the option of the Marketplace, the qualified individual provides satisfactory evidence to verify eligibility for an insurance affordability program or enrollment in a QHP following termination of Exchange enrollment due to a failure to verify such status within established time periods, or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify citizenship, status as a national or lawful presence.

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

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

- In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care;
- In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, coverage is effective for a qualified individual or enrollee on the first day of the following month.

For all other triggering events the effective dates are:

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

Specific Causes for Ineligibility

Except as described in the Continuation section, a Member **will become ineligible for coverage** under the EOC:

- When premiums are not paid according to the due dates and grace periods described in the Premium Section.
- For the spouse, when the spouse is no longer married to the Subscriber;
- For You and Your family Member(s) when You no longer meet the requirements listed in the Eligibility section;
- The date the EOC terminates.
- When the Member no longer lives in the Enrollment 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 qualify as Dependents for coverage under this EOC; except for Your failure to pay premium, the Member's insurance will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 60 days following the date this EOC would otherwise terminate. Coverage will continue without evidence of insurability.

Duplicate Enrollment

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

Students Taking a Medically Necessary Leave of Absence

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

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

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

EFFECTIVE DATE OF COVERAGE

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

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 ten (10) 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 of the last date for which You have paid Premiums.

If You purchased Your EOC from a Marketplace and You have elected to receive Your advanced premium tax credit, there is a grace period of ninety (90) consecutive 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. However if We do not receive Your Premium due in full before the end of the grace period, Your coverage will be terminated as of the last day of the first month of the grace period.

Please see 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.

Cancellation:

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

1. You fail to pay Your premiums as they become due or by the end of the applicable grace period.
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. When We cease to offer plans of this type to all individuals in Your class. In this event, state law requires that we do the following: (1) provide written notice to each Member of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage; (2) offer to each Member on a guaranteed issue basis the option to purchase any other individual hospital medical or surgical insurance coverage offered by Us at the time of discontinuation; and (3) act uniformly without regard to any health status related factors of a Member.
6. When We cease offering any plans in the individual market in North Carolina, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
7. When the Subscriber no longer works, lives, or resides in the Enrollment Area. This does not apply to a dependent child living outside of the Enrollment Area.
8. 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 $50 fee for 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 Member(s)
b. A change in age of any Member 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 Members in the same class and covered under the same EOC 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.

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

Certificate of Creditable Coverage

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

COVERED SERVICES AND BENEFITS

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

NOTE REGARDING PRIOR AUTHORIZATION OF INPATIENT SERVICES, OUTPATIENT SERVICES AND PRESCRIPTION DRUGS

Some services or therapies may require you to use particular Providers approved by Cigna for the particular service or therapy, and will not be covered if you receive them from any other Provider regardless of participation status.

Emergency Services and Urgent Care – What to Do if You Need Emergency/Urgent Care:

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but you do need to call your PCP or the CIGNA HealthCare 24-Hour Health Information Line SM as soon as possible for further assistance and advice on follow-up care.

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

If you require specialty care or a hospital admission, your PCP or the Cigna HealthCare 24-Hour Health Information Line SM will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

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

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

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

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Cigna Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than one hundred and eighty 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.

Physician Services

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

Second Surgical Opinion

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

Outpatient Services

Covered 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, recovery room services and services of a Freestanding Outpatient Surgical Facility.

Inpatient Hospital Services

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

(REMAINDER OF SERVICES ARE LISTED IN ALPHABETICAL ORDER)

Ambulance Service

Ambulance services to the nearest appropriate Provider or facility for treatment of an Emergency Medical Condition.

Autism Spectrum Disorders

Benefits are provided for:

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

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

1) a Physician licensed to practice medicine in all its branches or
2) a certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:
   a) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
   b) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
   c) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, that are intended to develop, maintain, and restore the functioning of an individual.

Covered Services include:

- Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, that are intended to develop, maintain, and restore the functioning of an individual.

Bariatric Surgery

This EOC provides benefits for Covered Charges made for medical and surgical services:

- for the treatment or control of clinically severe (morbid) obesity as indicated below, and
- if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition.
- Office Visits for the evaluation and treatment of obesity are limited to a maximum of four (4) visits per Calendar Year

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

The following items are specifically excluded:

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

Bone Mass Measurement Test

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

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

A Qualified Person means one who:

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

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

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

(d) is having primary hyperparathyroidism;

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

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

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

Cigna Telehealth Connection

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

- **Cigna Telehealth Connection Program:** services for the treatment of minor acute medical conditions such as colds, flu, ear aches, are available from a specific set of Providers known as Cigna Telehealth Connection Physicians. You can access Cigna Connection Telehealth Physicians by going to www.mycigna.com and click on Find Care and Cost, and scroll down to the middle of the page. You can initiate a telephone, email or online video visit for treatment of minor acute medical conditions such as a cold, flu, sore throat, rash or headache without referral from Your PCP. You may access Cigna Telehealth Connection Physicians by going to mycigna.com, then go to Find a Doctor page, then click on Cigna Telehealth Connection.

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

  The following services are covered:

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

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

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

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

Clinical Trials

Benefits are payable for routine patient services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements:

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition; and
2. Either
   - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
   - the covered person provides medical and scientific information establishing that his participation in such a trial would be appropriate based on the individual meeting the conditions described in Paragraph (1).

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

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be approved for cancer clinical trials by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;
- be conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

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

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

Routine Patient Services do not include:

- the investigational item, device, or service itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Congenital Treatment for Newborn, Foster and Adoptive Children

This EOC provides benefits for covered Charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your Newborn, foster and adoptive child from the moment of birth; and with the treatment of cleft lip or cleft palate.

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 are covered for eligible Dependent children.

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

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/Confinement/Anesthesia

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

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

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

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

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

Diabetes Services

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

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

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

Durable Medical Equipment

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

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

Family Planning Service

This EOC includes benefits for 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

Habilitative Services

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

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

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

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

Hearing Aid Coverage

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

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

Home Health Care 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 short-term services listed under the Rehabilitative Therapy Services section of this EOC.
- 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. **Home Health Care Services are limited to any combined maximum number of visits each Year as shown in the Benefit Schedule**.

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

This EOC provides benefits for Covered Expenses for Hospice Care Services 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 during the Illness and 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 Care 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

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

Internal Prosthetic/Medical Appliances

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

Laboratory and Diagnostic and Therapeutic Radiology Services

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

Lymphedema Diagnosis and Treatment

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

Mastectomy and Related Procedures

This EOC provides benefits for Covered Expenses for hospital and professional services for mastectomy and lymph node dissection for the treatment of breast cancer and for the treatment of physical complications of all stages of mastectomy, including lymphedemas, whether or not the mastectomy occurred while the Member was covered under this EOC. Benefits will be provided for Covered Expenses for inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. The decision to discharge a patient from a Hospital following a mastectomy will be made by the attending Physician in consultation with the patient based on the health and medical history of the patient.

If the Member elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

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

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

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

Maternity Care Services

Your HMO EOC provides pregnancy and post-delivery care benefits for You and Your Family Members.

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

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

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

Medical Supplies

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

Mental Health and Substance Use Disorder Services

This EOC provides benefits for Covered Services as indicated below for inpatient and outpatient evaluation and treatment of Mental Health and Substance Use Disorders. Mental Health and Substance Use Disorder services that are not covered by this EOC are listed in the "Benefit Exclusions and Limitations" section.

Inpatient Services
Benefits include Covered Services provided by a Hospital for the evaluation and treatment of Mental Health and/or Substance Use Disorder during an inpatient admission for acute care for conditions such as:

- a patient who presents a danger to self or others;
- a patient who is unable to function in the community;
- a patient who is critically unstable;
- a patient who requires acute care during detoxification; and
- the diagnosis, evaluation and acute treatment of addiction to alcohol and/or drugs.

Benefits also include Covered Services provided by a Mental Health or a Substance Use Disorder Residential Treatment Center for a Member who is confined in a Hospital or a Mental Health or Substance Use Disorder Treatment Residential Treatment Center as a registered bed patient, upon the recommendation of a Physician. Covered Services include hospitalization and residential treatment services provided by a Hospital or a Mental Health or Substance Use Disorder Residential Treatment Facility for the evaluation and treatment of psychological and social disturbances resulting from a subacute Mental Health or Substance Use Disorder condition that prevents a member from participating in treatment within the community and/or requires rehabilitation

Outpatient Services
Benefits include Covered Services by Providers who are qualified to treat Mental Health or Substance Use Disorders when treatment is provided on an outpatient basis for 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 thinking; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing and assessment, and medication management when provided in conjunction with a consultation. Covered Services include:

- Treatment of Mental Health conditions in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, family, group, partial hospitalization or intensive outpatient therapy setting.
- Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Use Disorder program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy totaling 9 or more hours in a week.
- Mental Health or Substance Use Disorder partial hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health or Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.
- Biofeedback only for pain management.

Nutritional Evaluation

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

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

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

Obstetrical and Gynecological Services

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

Orthognathic Surgery

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

Ostomy Supplies

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

Oxygen

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

Pediatric Dental Care Benefits

Pediatric dental care for Members less than 19 years of age are provided 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 the limiting age is reached

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

Covered Benefits for Members less than 19 years of age include:

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 high-powered spectacles, magnifiers and telescopes, which can aid the Member with their specific needs.

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

Exclusions

- Services not provided by a Cigna Vision In-Network Provider.
- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina **Worker's Compensation** Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act. Charges in excess of the usual and customary charge for the Service or Material.
- Charges incurred after the Evidence of Coverage ends or the Insured's coverage under the Evidence of Coverage ends, except as stated in the Evidence of Coverage.
- Experimental or Investigational or Unproven or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Benefits" within this section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lenses, treatments, "add-ons", or lens coatings not otherwise listed in "Covered Benefits." within this section, above.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- For or in connection with Experimental 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, You should visit **myCigna.com** and use the link on the vision coverage page.

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

Pediatric Vision Care Reimbursement/Filing a Claim

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

Positional Plagiocephaly

Medical Services are covered for the orthotic device to treat the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

Preventive Care Services – Periodic Health Examinations

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

- Routine physical exams including: guidance and counselling regarding substance use disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counselling.
- Two Smoking Cessation Attempts (maximum of 4 counselling sessions per attempt); Prescription Drugs for Smoking Cessation treatment are covered under the Prescription Drug benefit.
- Annual mammogram, Pap test and PSA.
- Items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF), including Nutritional and Genetic Counseling;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including all FDA approved contraceptive methods, and lactation counselling and a breast pump for nursing mothers.

Detailed information is available at: www.healthcare.gov

Note: Covered Services do not include routine examinations, care, screening or immunization for travel, (except for anti-malaria vaccinations), employment, school or sports.

Well Baby and Well Child Care

Covered Expenses include the following services for a Member:

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

Newborn Hearing Benefits

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

Adult Preventive Care

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

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

  Surveillance tests” mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination
- Charges for mammograms, including:
  - (a) a baseline mammogram
  - (b) a mammogram every other year
  - (c) or a mammogram every year if Medically Necessary and
  - (d) the Physician's interpretation of the laboratory results.

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

Smoking Cessation

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

All Other Routine Services

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

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

Coverage is provided for custom foot Orthoses and other Orthoses as follows:

- 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.
- Custom foot Orthotics 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.

Reconstructive Surgery

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

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

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

Services for Pulmonary and Cardiac Rehabilitation

This EOC provides benefits for Covered Expenses incurred for pulmonary rehabilitation and Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge.

The Phase II program must be Physician directed with active treatment and EKG monitoring.

Note: Phase III and Phase IV cardiac rehabilitation 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.

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

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

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

Benefits for Covered Expenses will be provided for the necessary care and treatment of loss or impairment of speech, payable up to the number of visits as stated in the Benefit Schedule. All supplies and additional fees charged in conjunction with these services will be included in the payment of benefits for the visit and will not be reimbursed in addition to the visit.

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

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

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

Sexual Dysfunction Services

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

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

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

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:

- 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.
- Cornea transplants are not covered by the LifeSOURCE Provider contracts, but are covered when received from a Participating Provider facility.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

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, contact Your Cigna case manager or 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:

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

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

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

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

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

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

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

Additional Service Available through LifeSOURCE Facilities

The following service is covered but ONLY when provided at a Cigna LifeSOURCE Transplant Network facility. The service is 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.

PRESCRIPTION DRUG BENEFITS

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

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

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the 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 www.cigna.com/ifp-drug-list.

Member Payments

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 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 (U&C) charge for the Prescription Drug.

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

Prescription Drugs Covered under the Medical Benefits

When Prescription Drugs 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 designated Limited Distribution Drug Provider which may be a home delivery Pharmacy 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 Medication and Infusion and Injectable Medication Benefits

Drugs Covered under the Prescription Drug Benefits

Self-Administered Injectable Medications, 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.

Medications Covered under the Medical Benefits

Medication, and Infusion and Injectable Medications on Cigna's Prescription Drug List are covered under the medical benefits of this EOC when:

Infusion and Injectable 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.

Patient Assurance Program

Your EOC offers additional discounts for certain covered Prescription Drugs that are dispensed by a Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this EOC, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your out of pocket expenses for certain covered Prescription Drugs for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drugs included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drugs as set forth in the benefit schedule may be reduced in order for Patient Assurance Program discounts or other payments earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.

For example, certain insulin drugs covered under the Prescription Drug benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program may result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in the benefit schedule, for the insulin drugs. In addition, the covered insulin drugs eligible for Patient Assurance Program discounts may not be subject to any applicable Deductible, if any.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drugs under the Patient Assurance Program applies toward your Out-of-Pocket Maximum.

Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drugs, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drugs. Except as may be noted elsewhere in this EOC, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drugs included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drugs, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drugs included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.

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 (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; 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.
- 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.
- Specialty Medications.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, when available for administration at a Pharmacy.

Covered Drugs or medicines must be all of the following:

- Prescribed in writing, except for insulin, by a Physician and dispensed within one year of being prescribed, subject to Federal or state laws.
- Approved for use by the Food and Drug Administration.
- For the direct care and treatment of the Member's Illness, Injury or condition; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Physician for the care and treatment of a Members Illness.
- Purchased from a licensed retail Pharmacy or ordered by mail through Express Scripts Pharmacy Cigna's home delivery Pharmacy.

- The Drug or medicine must not be used while the Member is an inpatient in any facility.
- The Prescription must not exceed the days' supply indicated in the "Limitations" section below.
- Infusion and Injectable Medications and Specialty Medications may require Prior Authorization or Step Therapy.

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

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

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

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

Prescription Drug Exclusions

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

- Drugs not approved by the Food and Drug Administration.
- Drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process;
- 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);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin.
- Drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
- Drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
- Injectable infertility drugs except as covered under this EOC, 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 drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- 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;
- Drugs used for weight loss, weight management, metabolic syndrome; and antiobesity agents.
- Drugs that are Experimental or Investigational or Unproven, except as specifically stated in the section of this EOC titled “Clinical Trials” or “Off Label Drugs”.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals.
- Implantable contraceptive products are covered under the medical benefits of the EOC.
- 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.
- 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).
- 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.
- Medications used for travel prophylaxis, except for anti-malarial drugs.
- Drugs obtained outside of the United States.

- 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.
- Drugs used to enhance athletic performance.
- 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.
- 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.
- Drug convenience kits.
- Any prescriptions more than one year from the original date of issue.
- Any costs related to the mailing, sending or delivery of Prescription Drugs.
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Member.

Prescription Drug Benefit 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 90 day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the EOC Benefit Schedule); or.
- Up to a 90 day supply, at a 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 90 Day Retail Pharmacy you can call the Customer Service number on Your ID card or go to www.cigna.com/ifp-providers (for detailed information about drug tiers please refer to the EOC Benefit Schedule).
- Up to a 90 day supply at Express Scripts Pharmacy, 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 please refer to the EOC 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.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- You cannot refill a prescription until the 30-90 day retail, or 90 day mail-order supply has been used, except during a declared state of emergency or disaster.

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

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. If a Prescription Drug or Related Supply is subject to a Step Therapy Requirement, then You must try one or more Prescription Drugs and Related Supplies, before the EOC will cover the requested Prescription Drug or Related Supply. The Prescription Drugs and Related Supplies that require Step Therapy can be identified on the Prescription Drug List at www.mycigna.com. 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 Prescription Drug or Related Supply 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 Prescription Drugs or Related Supplies (or new FDA-approved indications) are designated as Non-Prescription Drug List Prescription Drugs or Related Supplies until the Cigna business decision team makes a placement decision on the new Prescription Drug or Related Supply (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 Prescription Drugs or Related Supplies (or new FDA approved indications) within 90 days of its release to the market. The business decision team must 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 Express Scripts Pharmacy Cigna's Home Delivery Pharmacy, 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:
Express Scripts Pharmacy
P.O. Box 1019
Horsham PA 19044-1019
1-800-835-3784

Forms are also available online at www.mycigna.com.

The address to which You must mail paper claim forms is subject to change. Please check www.mycigna.com or call the toll-free customer service number on the back of your ID card to confirm the appropriate mailing address for any claim form you wish to send. If You or Your Family Member(s) have any questions about the Prescription Drug benefit, call the toll-free customer service number on the back of Your ID card**.**

BENEFIT EXCLUSIONS AND LIMITATIONS

Benefit Exclusions

The following are specifically excluded from coverage under this EOC:

1. Any services for health conditions which have not been provided by your PCP, or provided by Referral from Your PCP or authorized by the Cigna Medical Director, except for immediate treatment of an Emergency Medical Condition.
2. Services obtained from a Non-Participating (Out-of-Network) Provider, except as stated under "Special Circumstances" in the "Introduction section of this EOC.
3. Services received before the Effective Date of coverage under this EOC.
4. Services received after coverage under this EOC ends.
5. Custodial Care, including but not limited to rest cures; infant, child, or adult day care, including geriatric day care.
6. Care required by state or federal law to be supplied by a public schools system or school district.
7. Any amounts in excess of the maximum benefit limitations of Covered Expenses stated in this EOC.
8. Services that are not Medically Necessary.
9. Services not specifically listed as Covered Services in this EOC.
10. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
11. Treatment of an Illness or Injury which is due to war, declared or undeclared. This does not apply to illness or injury due to an act of terrorism.
12. Charges for which you have no legal obligation to pay or for which no charges would be made if you did not have a health plan or insurance coverage.
13. 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.
14. Services of a Hospital emergency room for any condition that is not an Emergency Medical Condition as defined in this EOC
15. 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.
16. Any services and supplies for or in connection with Experimental, Investigational or Unproven services. Experimental, Investigational or Unproven services do not include routine patient care costs related to qualified clinical trials as described in your EOC document.

17. 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 a 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 depilation; 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.
18. The following services are excluded from coverage;
    - Macromastia or Gynecomastia Surgeries;
    - Surgical treatment of varicose veins;
    - Abdominoplasty;
    - Panniculectomy;
    - Rhinoplasty;
    - Blepharoplasty;
    - Redundant skin surgery;
    - Removal of skin tags;
    - Craniosacral/cranial therapy;
    - Applied kinesiology;
    - Rolfing;
    - Prolotherapy; and
    - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
19. Dental treatment of the teeth, gums or structures directly supporting the teeth, including but not limited to dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition, except as provided under the Pediatric Dental Care benefit. This does not apply to dental treatment covered under the "Dental Confinement and Anesthesia" benefit in this EOC.
20. Any medical and surgical services for the treatment or control of obesity except as otherwise stated under the "Services and Benefits" section of this EOC.
21. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
22. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Services and Benefits."

23. All services related to In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
24. Reversal of male and female voluntary sterilization procedures.
25. 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.
26. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the EOC.
27. Charges for animal to human organ transplants.
28. Non-medical counseling or ancillary services including, but not limited to education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation, except as specifically stated in this EOC.
29. All services related to Applied Behavioral Therapy treatment**,** including but not limited to: the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior
30. 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.
31. Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; light therapy; aromatherapy; music or sound therapy; dance therapy; movement therapy, sleep therapy; hypnotism; rolfing; 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.
32. 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
33. Educational services except for Diabetes Self-Management Training; treatment for Autism, counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) or and as specifically provided or arranged by Cigna.

34. All Foreign Country Provider services, except as stated in this EOC under “Covered Services and Benefits”.

35. 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. Cranial banding/cranial orthoses/other similar devices, 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 prefabricated foot orthoses; orthopedic shoes (except when joined to braces), shoe inserts; foot orthotic devices except as required by law for diabetic patients. 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.

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

    a. Hygienic or self-help items or equipment;

    b. 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;

    c. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;

    d. Institutional equipment, such as air fluidized beds and diathermy machines;

    e. Elastic stockings; except for treatment of diabetes, and wigs;

    f. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;

    g. 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;

    h. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and

    i. Hearing aid batteries (except those for cochlear implants) and chargers.

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

38. 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.

39. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in “Services and Benefits” section of the EOC.
40. 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.
41. Eyeglass lenses and frames and contact lenses; except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery, or those covered under Pediatric Vision benefit.
42. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
43. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and Experimental, Investigational and Unproven drugs, except as provided in "Services and Benefits.”
44. 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.
45. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
46. Genetic screening; except for testing for the occurrence of BRCA gene (breast cancer related genetic marker) under federal preventative care for women. 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.
47. 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.
48. Blood administration for the purpose of general improvement in physical condition.
49. Cost of biologicals that is immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
50. Cosmetics, dietary supplements and health and beauty aids.
51. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
52. 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).
53. Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

54. Conditions caused by: (a) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (b) a Member participating in the military service of any country; (c) a Member participating in an insurrection, rebellion, or riot (d) services received as a direct result of a Member commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Member being engaged in an illegal occupation;
55. Massage therapy.
56. 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;
57. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
58. Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
59. Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
60. Counseling for activities of an educational nature for borderline intellectual functioning; for occupational problems, related to consciousness raising, marriage counseling and vocational or religious counseling.
61. I.Q. testing.
62. 59. Residential treatment, , except as otherwise stated under “Mental Health and Substance Use Disorders Services” in the “Covered Services and Benefits” section
63. Psychological testing on children requested by or for a school system
64. Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline
65. Claims received by Cigna after 18 months from the date service was rendered, except in the event of a legal incapacity

Benefit Limitations

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

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

Start with Member Services.

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

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

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

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

Appeals Procedure

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

Cigna HealthCare of North Carolina, Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

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

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

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

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

Expedited Appeals

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

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

Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, We will consult with a Physician who is licensed to practice medicine in North Carolina, and will respond orally with a decision within 72 hours, followed up in writing within the lesser of two working days or four calendar days. If the expedited review is a concurrent review determination, Cigna will remain liable for health care services until the Member has been notified of the determination.

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

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

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External Review

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

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

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

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

Standard External Review Procedure

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

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

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

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

Cigna HealthCare of North Carolina, Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

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

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

Expedited External Review Procedure

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

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

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

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

External Review Contact

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

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Telephone: 855-408-1212(Toll-free)

In Person:
Health Insurance Smart NC
11 South Boylan Avenue
Raleigh, NC 27603
1-855-408-1212 (Toll-free)
www.ncdoi.com/Smart for External Review information and Request Form

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

Notice of Benefit Determination on Appeal

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

Relevant Information

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

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

Workers' Compensation

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

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

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.

Recovery of Excess Benefits

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

Other Insurance With This Insurer

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

Insurance With Other Insurers

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

Medicare 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

Right to Receive and Release Information

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

AMENDMENT OR MODIFICATION OF EOC

Amendment or Modification by Consent of the Parties

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

Amendment or Modification by Notice from Cigna

Cigna may amend or modify the provisions of this EOC, including any Premiums and Copayments, by giving at least thirty-sixty (30-60) days' prior written notice to the Subscriber.

Uniform Modification of Coverage

The provisions of this EOC may be modified to reflect product revisions which have uniformly been made to this Individual and Family Plan EOC. Cigna reserves the right to modify this EOC, including EOC provisions, benefits and coverages, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under this same EOC form. We will only modify this EOC for all Members in the same class and covered under the same EOC form, and not just on an individual basis.

Cigna will send written notice and the change will become effective on the date shown in the notice or on the next scheduled premium due date thereafter. Payment of the premiums will indicate acceptance of the change.

Amendment or Modification by Law or Regulation

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

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.

MISCELLANEOUS

Member Services/Additional Programs:

We may, from time to time offer, or arrange for various entities to offer, discounts, benefits, Premium or cost share credits, or other consideration to You for the purpose of promoting Your general health and well-being.

Relationships

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

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

Notice

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

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

Proof of Loss

You must give Us written proof of loss within 18 months after the date of the loss, except in absence of legal capacity. Proof of loss is a claim form as described above. Canceled checks or receipts are not acceptable. Cigna will not be liable for benefits if it does not receive written proof of loss within this time period.

Entire EOC Changes

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

Time Limit on Certain Defenses

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

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

Severability

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

No Implied Waiver

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

Records

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

Physical Examination and Autopsy

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

Clerical Error

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

Misstatement of Age

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

Administrative Policies Relating to This EOC

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

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

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

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

Conformity With State and Federal Statutes

If any provision of this EOC which, on its Effective Date, is in conflict with the statutes of the state in which it was issued or a federal statute, it is amended to conform to the minimum requirements of those statutes.

Access to Information Relating to Provider Services

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

EOC Binding on Members

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

Applications, Statements, etc.

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

Successors and Assigns

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

Identification Card

Cards issued by Cigna to Members pursuant to this EOC are for identification only. Possession confers no right to services or other benefits under this EOC. To be entitled to such services or benefits the holder must, in fact, be a Member on whose behalf all Charges and Member payments under this EOC have actually been paid. 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.