Cigna HealthCare of Illinois, Inc. (referred to herein as Cigna) may change the Premiums of this EOC after 60 days' written notice to the Member. However, We will not change the Premium schedule for this EOC on an individual basis, but only for all Members in the same class and covered under the same plan as You. We will only change Premiums on an Annual basis.

Cigna HealthCare of Illinois, Inc.
INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE
Cigna Connect 5000 and Cigna Connect 5000-1

If You Wish To Cancel 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 30028
Tampa, FL 33630-3028

Include your Cigna identification number with any correspondence. This number can be found on your Cigna identification card. You can also call the number on the back of your ID card for information.

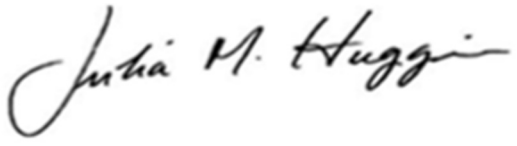
THIS EOC MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This EOC was issued to You by Cigna HealthCare of Illinois, Inc. (referred to herein as Cigna) based on the information You provided in Your application. If You know of any misstatement in Your application, You should advise the Company immediately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

THIS IS NOT A MEDICARE SUPPLEMENT EOC AND WILL NOT DUPLICATE MEDICARE BENEFITS.

Guaranteed Renewable

This EOC is monthly medical coverage subject to continual payment by the Subscriber. Cigna will renew this EOC except for the specific events stated in the EOC. Coverage under this EOC is effective at 12:01 a.m. **Eastern time** on the Effective Date shown on the EOC's specification page.

Signed for Cigna by:



Julia M. Huggins, President

Jill Stadelman, Corporate Secretary

IMPORTANT NOTICES

Direct Access to Obstetricians and Gynecologists

You do not need Prior Authorization from the plan or from any other person (including your Primary Care Physician) 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 Physician

This plan may require or allow the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in the network and who is available to accept You or Your Family Members. Cigna may designate one for you until you make this designation. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, 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 Physician.

Right to Return Contract

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

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Introduction

About This EOC

Your medical coverage is provided under an Evidence of Coverage (EOC) issued by Cigna HealthCare of Illinois, Inc. (referred to herein as Cigna). This EOC is a legal contract between You and Us.

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 Family Member(s) who are enrolled for coverage under this EOC. You and all Family Member(s) covered under this EOC are listed on the EOC specification page.

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 Family Member(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 Family Member(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 OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS COVERAGE AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN 2 YEARS AFTER ADDING ADDITIONAL FAMILY MEMBER(S) (EXCLUDING NEWBORN CHILDREN ADDED WITHIN 60 DAYS AFTER BIRTH), WE DISCOVER ANY FRAUD OR MATERIAL FACTS THAT WERE INTENTIONALLY MISREPRESENTED OR THAT YOU OR YOUR FAMILY MEMBER(S) KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER(S) AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE. IF WE RESCIND YOUR COVERAGE, WE WILL 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 EXCEED TOTAL PREMIUMS PAID, THEN CLAIMS PREVIOUSLY PAID BY CIGNA WILL BE RETROACTIVELY DENIED, OBLIGATING YOU TO PAY THE PROVIDER IN FULL FOR SERVICES RENDERED AT THE PROVIDER'S REGULAR BILLED RATE, NOT AT THE CIGNA NEGOTIATED RATE.

Choice of Hospital and Physician: Nothing contained in this EOC restricts or interferes with a Member's right to select the Hospital or Physician of their choice. However, non-Emergency Services from a Non-Participating Provider are not covered by this EOC.

THIS IS AN HMO EOC

That means this EOC does not provide benefits for any services you receive from an Out-of-Network Provider except:

- Services for Stabilization and initial treatment of an Emergency Medical Condition, or
- Medically Necessary services that are not available through an In-Network Provider.

In-Network Providers include Physicians, Hospitals, and Other Health Care Facilities. Check the provider directory, available at www.mycigna.com, or call the number on your ID card to determine if a Provider is In-Network.

Choosing a Primary Care Physician (PCP)

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 Family Member(s). You have the right to designate any Primary Care Physician who participates in Our network for this plan and is available to accept You or Your Family Members. If you do not choose a PCP, We may select a PCP for you.

Referrals to Specialists

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

Exceptions to the Referral process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Covered Services and Benefits," without a Referral from your PCP. You do not need a PCP Referral for Virtual Care Services.

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.

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

Standing Referral to Specialist

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

1. You are a covered Member of the Cigna 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. A standing Referral may be effective for up to 12 months and may be renewed and re-renewed by your PCP. If you receive a standing Referral or any other Referral from your PCP, that Referral remains in effect even if the PCP ceases to be a Participating Physician. If the treating specialist leaves Cigna's network or you cease to be a covered Member, the standing Referral expires.

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 www.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 Physician Leaves the Network

If your PCP or 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 specialist to continue providing Covered Services. If you do not choose a PCP after being notified that your PCP is no longer a Participating Provider, We may 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 or specialist 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 Physician 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:

- Successful transition of your care to a Participating Provider; or
- Completion of your treatment; or
- The next Annual Open Enrollment Period; or
- The length of time approved for continuity of care ends.

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 are enrolled as a 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 Cigna, 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.

Service Area Restrictions

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

Important Information Regarding Benefits

Prior Authorization Program

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

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION to a Hospital or certain other facilities MAY RESULT IN A PENALTY OR DENIAL OF PAYMENT FOR THE SERVICES PROVIDED.

Prior Authorization can be obtained by You, Your Family Member(s) or the Provider by calling the number on the back of your ID card.

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

- call Cigna at the number on the back of your ID card, or
- check www.mycigna.com, under "Coverage" then select "Medical."

Please note that emergency admissions will be reviewed post admission.

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

PRIOR AUTHORIZATION FOR OUTPATIENT SERVICES

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

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

To verify Prior Authorization requirements for outpatient procedures and services, including which procedures and services require Prior Authorization, you can:

- call Cigna at the number on the back of your ID card, or
- check www.mycigna.com, under "Coverage" then select "Medical."

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this EOC limitations and exclusions, payment of Premium and eligibility at the time care and services are provided.

Retrospective Review

If Prior Authorization was not performed, Cigna will use retrospective review to determine if a scheduled or emergency admission was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this EOC. If it is determined that a service was not Medically Necessary, Cigna will not cover any Charges for that service.

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

Prior Authorization is required for certain Prescription Drugs and Related Supplies. **For complete, detailed information about Prescription Drug Authorization procedures, exceptions and Step Therapy, please refer to the section of this EOC titled "Prescription Drug Benefits."**

To verify Prior Authorization requirements for Prescription Drugs and Related Supplies, including which Prescription Drugs and Related Supplies require Authorization, you can:

- call Cigna at the number on the back of your ID card, or
- log on to www.cigna.com/ifp-drug-list.

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.

BENEFIT SCHEDULE

The following is the EOC benefit schedule, including medical, prescription drug and pediatric vision benefits. The EOC sets forth, in more detail, the rights and obligations of all Members and Cigna. It is, therefore, important that all Members **READ THE ENTIRE EOC CAREFULLY!**

Remember, services from Non-Participating (Out-of-Network) Providers are not covered except for initial care to treat and Stabilize an Emergency Medical Condition. For additional details see the "How The EOC Works" section of Your EOC.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Medical Benefits	
Deductible **Individual** **Family** Deductible applies unless specifically waived.	 $5,000 $10,000
Coinsurance	50%
Out-of-Pocket Maximum **Individual** **Family**	 $8,700 $17,400
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 for more detailed information. 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 "Coverage" then select "Medical."	 **Your Participating Provider must obtain approval** for inpatient admissions. Failure to do so may result in a penalty or denial of payment for services provided. **Your Participating Provider must obtain approval** for selected outpatient procedures and services. Failure to do so may result in a penalty or denial of payment for services provided.

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
All Preventive Care Services Please refer to "Comprehensive Benefits: What the EOC Pays For" section of this EOC for additional details	0%, Deductible waived
Pediatric Vision Care Performed by an Ophthalmologist or Optometrist for a Member, through the end of the month in which the Member turns 19 years of age. Please be aware that the pediatric vision network is different from the network of your medical benefits. **Comprehensive Eye Exam** Limited to one exam per Year **Eyeglasses for Children** Limited to one pair per Year Pediatric Frames, Single Vision, Lined Bifocal, Lined Trifocal or Standard Progressive and Lenticular Lenses **Contact Lenses for Children** Annual limits apply Elective and Therapeutic **Low Vision Services and Aids** Annual limits apply	 0%, Deductible waived 0%, Deductible waived 0% per pair, Deductible waived 0%, Deductible waived
Physician Services **Office Visit** **Primary Care Physician** (PCP) **Specialist** (including consultant and second opinion services)	 $75 Copayment per visit, Deductible waived $90 Copayment per visit, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Other Physician Services	
Surgery in Physician's office	50%
Outpatient Professional Fees (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy)	50%
Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy	50%
In-hospital visits	50%
Allergy testing and treatment/injections	50%
Virtual Care	
Dedicated Virtual Care Medical Physician Service For minor acute medical conditions	$0 Copayment per visit, Deductible waived
Virtual Care Service from Participating Physicians other than Dedicated Virtual Care Physicians (This benefit excludes any services that are delivered via telephone only.)	Same benefit as when service provided in person
Note: Any Prescription issued during a virtual visit is subject to all Prescription Drug Benefits, limitations and exclusions.	
Indian Health Program / Tribal Health Program Services* Any Covered Services provided by an Indian Health Program or Tribal Health Program **Note:** these benefits apply **only** to a Member who is either a member of a federally-recognized Native American tribe or an Alaska Native **and who is enrolled in a plan purchased through the Marketplace**. ***See the Definitions section in the EOC for additional information on "Indian Health Program" and the "Tribal Health Program."**	0%, Deductible waived
Second Surgical Opinion	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Hospital Services	
Inpatient Hospital Services	
Facility Charges	50%
Professional Charges	50%
Emergency Admissions	Benefits are shown in the Emergency Services schedule
Facility Charges	
Professional Charges	
Outpatient Facility Services Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities	50%
Advanced Radiological Imaging (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation Charges	50%
All Other Laboratory and Radiology Services Facility and interpretation Charges	
Physician's Office	50%
Free-standing	
Independent Lab	50%
X-ray Facility	50%
Outpatient Hospital	
Lab	50%
X-ray	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Rehabilitative Services	
Physical Therapy	50%
Occupational Therapy	50%
Speech Therapy	50%
Chiropractic Treatment Maximum of 25 visits per Member per Calendar Year.	50%
Naprapathic Services Maximum of 15 visits per Member, per Calendar Year	50%
Cardiac & Pulmonary Rehabilitation Maximum of 36 visits per Member within a 6 month period.	50%
Habilitative Services	
Physical Therapy	50%
Occupational Therapy	50%
Speech Therapy	50%
Hearing Aids Maximum of 1 per ear every 24 months for adults and children. Dollar maximums do not apply.	50%
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	50%
Women's Contraceptive Services, Family Planning and Sterilization	0%, Deductible waived
Male Sterilization	0%, Deductible waived

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Maternity (Pregnancy and Delivery)/ Complications of Pregnancy (including Spontaneous and Elective Abortion)	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office Visit benefit applies
Prenatal services, Postnatal and Delivery billed as "global" fee	50%
Hospital Delivery	Inpatient Hospital Services benefit applies
Prenatal testing or treatment billed separately from "global" fee	Copayment or Coinsurance applies for specific service provided
Postnatal visit or treatment billed separately from "global" fee	Copayment or Coinsurance applies for specific service provided
Autism Spectrum Disorders	
Diagnosis of Autism Spectrum Disorder	
Office Visit	PCP or Specialist Office Visit benefit applies
Diagnostic testing	50%
Treatment of Autism Spectrum Disorder (see "Comprehensive Benefits: What the EOC Pays For" section for specific information about what services are covered)	Copayment or Coinsurance applies for specific benefit provided
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities	50%
Home Health Care Services	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Durable Medical Equipment	50%
Prosthetics	50%
Hospice	
Inpatient	50%
Outpatient	50%
Dialysis	
Inpatient	Inpatient Hospital Services benefit applies
Outpatient	50%
Mental Health Disorder	
Inpatient (includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Outpatient (includes individual, group, intensive outpatient and partial hospitalization)	
Office Visit	PCP Office Visit benefit applies
All other outpatient services	50%

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Substance Use Disorder	
Inpatient Rehabilitation (includes Acute and Residential Treatment)	Inpatient Hospital Services benefit applies
Inpatient Detoxification	Inpatient Hospital Services benefit applies
Outpatient (includes individual, group, intensive outpatient and partial hospitalization)	
Office visit	PCP Office Visit benefit applies
All other outpatient services	50%
Organ and Tissue Transplants	
Cigna LifeSOURCE Transplant Network® Facility **Travel Benefit** (Only available through Cigna LifeSOURCE Transplant Network® Facility) Travel benefit Lifetime maximum payment of $10,000	0%
Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services	Inpatient Hospital Services benefit applies
Participating Facility NOT specifically contracted to perform Transplant Services	Not Covered
Ventricular Assist Device Services	
Cigna LifeSOURCE Transplant Network® Facility	0%
Non-LifeSOURCE Participating Facility specifically contracted to perform Ventricular Assist Device Services	Inpatient Hospital Services benefit applies
Participating Facility NOT specifically contracted to perform Ventricular Assist Device Services	Not Covered

BENEFIT INFORMATION Note: Covered Services are subject to applicable Deductible unless specifically waived.	PARTICIPATING PROVIDER (Based on the Negotiated Rate for Covered Expenses) YOU PAY
Infusion and Injectable Medications and related services or supplies Administered by a medical professional in an office or outpatient facility	50%
Dental Care (other than Pediatric) Limited to treatment for accidental Injury to natural teeth within 6 months of the accidental Injury.	50%
Specified Diabetic Services and Supplies	0%, Deductible waived
Infertility **(see "Covered Services and Benefits" section for specific information about what services are covered and benefit limits which may apply)**	Benefit depends on type of service provided
Bariatric Surgery	Benefit depends on type of service provided

BENEFIT INFORMATION **Emergency Services** **This EOC covers Emergency Services from Participating and Non-Participating Providers; Covered Services are subject to applicable 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 Allowed Expense for Covered Expenses
	Please note: With respect to the Cost Sharing amounts shown below, You will be responsible for only the amount of Non-Participating Provider Covered Expenses that You would have incurred if You received the services from an In-Network Provider. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider, and as such benefits will be provided to you at no greater cost than if you received them from a Participating Provider. You are also responsible for: all Charges that are not Covered Expenses under this EOC.	
Hospital Emergency Room		
Emergency Medical Condition	50%	In-Network Cost Share applies
Non-Emergency Medical Condition	Not Covered (You pay 100% of Charges)	Not Covered (You pay 100% of Charges)
Urgent Care Center Facility		
Emergency Medical Condition	$50 Copayment per visit, Deductible waived	In-Network Cost Share applies
Non-Emergency Medical Condition	$50 Copayment per visit, Deductible waived	Not Covered (You pay 100% of Charges)
Ambulance Services **Note:** coverage for Medically Necessary transport to the nearest facility capable of handling the Emergency Medical Condition		
Emergency Transport	50%	50%
Treatment of Sexual Assault Victims	0%, Deductible waived	In-Network Cost Share applies

BENEFIT INFORMATION **Emergency Services** **This EOC covers Emergency Services from Participating and Non-Participating Providers; Covered Services are subject to applicable 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 Allowed Expense for Covered Expenses
	Please note: With respect to the Cost Sharing amounts shown below, You will be responsible for only the amount of Non-Participating Provider Covered Expenses that You would have incurred if You received the services from an In-Network Provider. We will ensure that You are held harmless for any amounts beyond the Copayment, Deductible and Coinsurance percentage You would have paid had You received the services from a Participating Provider, and as such benefits will be provided to you at no greater cost than if you received them from a Participating Provider. You are also responsible for: all Charges that are not Covered Expenses under this EOC.	
Inpatient Hospital Services (for emergency admission to an acute care Hospital)		
Hospital Facility Charges (Emergency Services from a Non-Participating Provider are covered at the In-Network benefit level until the patient is transferrable to a Participating facility. Non-Participating facility benefits are not covered once the patient can be transferred, whether or not the transfer takes place.)	50%	In-Network Cost Share applies until transferable to an In-Network Hospital; if not transferred then Not Covered (You pay 100% of Charges)
Professional Services	50%	In-Network Cost Share applies until transferable to an In-Network Hospital; if not transferred then Not Covered (You pay 100% of Charges)

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	
Prescription Drugs Benefits		
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 Pharmacy, Cigna's 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 this benefit schedule. For insulin drugs covered by this EOC your Cost Share amount will be capped so that the amount you are required to pay for a covered prescription insulin drug will not exceed $100 dollars per 30 day supply.		
Prescription Drug Deductible	The Individual and Family Deductible shown on the first page of the benefit schedule applies to Prescription Drugs and Related Supplies.	
	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.	50% per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy.	50% per Prescription or refill Up to a 90-day maximum supply
Tier 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.	50% per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy.	50% per Prescription or refill Up to a 90-day maximum supply

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	
Tier 3: This tier typically includes preferred Brand Name Drugs and some high cost Generic Drugs.	40% per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy.	40% per Prescription or refill Up to a 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 Up to a 90-day maximum supply
Tier 5: This tier typically includes Specialty Medications and high cost Generic and Brand Name Drugs.	50% per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy.	50% per Prescription or refill Up to a 90-day maximum supply
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 available; and ▪ smoking cessation products, limited to a maximum of 2 90-day treatment 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 Up to a 90-day maximum supply

Definitions

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

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 or 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 or Related Supplies.

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

1. the Ryan White HIV/AIDS Program established under Title XXVI 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.

Allowed Expense is the amount that Cigna may cover for services rendered by a Non-Participating Provider consistent with applicable law.

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.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

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 units of Cigna or its affiliates that is duly authorized by Cigna to make recommendations regarding coverage treatment of Prescription Drugs and Related Supplies based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drugs and Related Supplies.

Charges means the actual billed charges; except when the Provider has contracted with Cigna for a different amount, including where Cigna has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

Cigna, We, Our, and Us mean Cigna HealthCare of Illinois, Inc. or an affiliate, a health maintenance organization (HMO). Cigna is a licensed and regulated insurance company operating throughout the United States.

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

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

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

Copayment means a set dollar amount of Covered Expenses the Member is responsible for paying. Copayment does not include Charges for services that are not Covered Services or Charges in excess of Covered Expenses. Copayments are calculated separately from Coinsurance.

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

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

Covered Expenses are the expenses incurred for Covered Services under this EOC which Cigna will consider for payment under this EOC. Covered Expenses are:

- The Negotiated Rate for Covered Services from Participating Providers.
- The Allowed Expense.

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

Covered Expenses may be limited by other specific maximums described in this EOC. Covered Expenses are subject to 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) a Hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another appropriately licensed organization, and

   (iii) acting within the scope of the Provider's license and (if applicable) accreditation.

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

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

Dedicated Virtual Care Medical Physician Service means a Virtual Care Service provided by a Dedicated Virtual Care Physician for minor acute medical conditions such as a cold, flu, sore throat, rash or headache.

Dedicated Virtual Care Physician means a Physician who is part of a designated network from one or more organizations contracted with Cigna to provide Virtual Care Services for minor acute medical conditions.

Deductible means the amount of Covered Expenses that must be paid for Covered Services each Year before benefits are available under this EOC. The Deductible applies to all Covered Expenses unless Your plan includes a separate Prescription Drug Deductible that would apply to only those benefits, which would be shown in the Prescription Drug section of this EOC.

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

Diabetic Equipment includes blood glucose monitors, monitors designed to be used by blind persons; insulin pumps and associated appurtenances; 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; and podiatric appliances for the prevention of complications associated with diabetes. Diabetic Equipment also includes 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.

Diabetic Pharmaceuticals & Supplies include visual reading and urine test strips; ketones and protein test strips; blood glucose monitors, therapeutic continuous glucose monitors and the associated supply items on Cigna's Prescription Drug List; lancets and lancing devices; insulin and insulin analogs; injection aids, including devices used to assist with insulin injection and needle-less systems; syringes and hypodermic needles, prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition:

(a) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and

(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

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

Essential Health Benefits: 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 Illinois, Inc. Individual plan Evidence of Coverage document, the benefit schedule, 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, III or IV 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 Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this EOC. It is an accumulation of the Individual Deductibles paid by each Family Member 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 Family Deductible applies to all Covered Expenses unless Your plan includes a separate Prescription Drug Deductible that would apply to only those benefits, which would be shown in the Prescription Drug section of this EOC. The amount of the Family Deductible is described in the benefit schedule of this EOC.

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

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

Family Prescription Drug Deductible applies if You and one or more of Your Family Member(s) are enrolled for coverage under this EOC and Your plan includes a separate Prescription Drug Deductible. It is an accumulation of the Individual Prescription Drug Deductible paid by each Family Member during a Year. Each Member can contribute up to the Individual Prescription Drug Deductible amount toward the Family Prescription Drug Deductible. Once the Family Prescription Drug Deductible amount is satisfied in a Year, any

remaining Individual Prescription Drug Deductibles will be waived for the remainder of the Year. The amount of the Family Prescription Drug Deductible is described in the Prescription Drug section of the benefit schedule.

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

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

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

Gene Therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each Gene Therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of Gene Therapy, based in part on the nature of the treatment and how it is distributed and administered.

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

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

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

Hospice Care Services means palliative and supportive medical, nursing and other health services through home or inpatient care that are Covered Expenses provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Agency and Visiting Nurse Associations, (d) a hospice facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospital means:

- an institution licensed as a Hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses; or
- an institution which qualifies as a Hospital, a psychiatric Hospital 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.

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.

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

Individual Deductible means the amount of Covered Expenses each Member must pay for Covered Services each Year before benefits are available under this EOC. The amount of the Individual Deductible is described in the benefit schedule section of this EOC. The Individual Deductible applies to all Covered Expenses unless Your plan includes a separate Prescription Drug Deductible that would apply to only those benefits, which would be shown in the Prescription Drug section of this EOC. The amount of the Individual Deductible is described in the benefit schedule of this EOC.

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 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 Pharmacy services for Covered Expenses incurred during the remainder of that Year. Non-compliance penalty charges do not apply to the Individual Out-of-Pocket Maximum and will always be paid by you. The amount of the Individual Out-of-Pocket Maximum is described in the benefit schedule section of this EOC.

Individual Prescription Drug Deductible means the amount of Covered Expenses each Member must pay for Prescription Drugs and Related Supplies each Year before benefits are available for Prescription Drugs and Related Supplies under this EOC if Your plan includes a separate Prescription Drug Deductible. The amount of the Individual Prescription Drug Deductible is described in the benefit schedule section of this EOC, in the Prescription Drug Benefits.

Infertility is the condition of an otherwise presumably healthy individual who is unable to conceive or produce conception during a period of one Year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Infusion and Injectable Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional. 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.

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

Medically Necessary or Dentally Necessary services or supplies are those that are determined by Cigna to be **all** of the following:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical or dental condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration.
- Provided for the diagnosis or direct care and treatment of the medical or dental condition.
- Not primarily for the convenience of any Member, Physician, or another Provider.
- Within generally accepted standards of good medical practice within the community of qualified professionals.
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.
- The most appropriate procedure, supply, equipment or service which can be safely provided and that satisfies the following requirements:

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

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

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

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

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 both You (the Subscriber), and all other Family Members who are covered under this EOC.

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

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.

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

Newborn is an infant within 31 days of birth.

Non-Participating Pharmacy/Out-of-Network Pharmacy is a retail or home delivery Pharmacy which Cigna has NOT contracted with to provide 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 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 Health Care Facility means a facility other than a Hospital or hospice facility which is operated by or has an agreement with Cigna to render services to Members. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing facilities, rehabilitation Hospitals and sub-acute facilities. Other Health Care Facilities do NOT include long-term care facilities, residential facilities, care homes, rest homes, or assisted living facilities.

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

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

Participating Pharmacy/In-Network Pharmacy is a retail Pharmacy which Cigna has contracted with to provide Prescription Drug services to Members or Cigna's designated home delivery Pharmacy which Cigna has contracted with to provide home delivery Prescription Drug services to Members.

Participating Provider/In-Network Provider means:

- Hospitals, Physicians, and Other Health Care Facilities or Professionals 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 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)
The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pediatric Vision Services means vision care examinations and other services or treatment described in the "Pediatric Vision Services" section of this EOC provided to a Member who is under age 19.

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 is 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.

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

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.

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

Prescription Drug is 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 Deductible means the amount of Covered Expenses that must be paid for Prescription Drugs and Related Supplies each Year before benefits for Prescription Drugs and Related Supplies are available under this EOC and Your plan includes a separate Prescription Drug Deductible. The Prescription Drug Deductible does accumulate toward satisfying the Out-of-Pocket Maximum(s).

Prescription Drug List is 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 parameters established by the P&T Committee and the Business Decision Team. The Prescription Drug List is regularly reviewed and updated. You can view the drug list at www.mycigna.com.

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

Primary Care Physician (PCP) is a Physician:

- who is a general practitioner, internist, family practitioner or pediatrician; and

- who has been selected by the Member to provide or arrange for medical care and specialized services for the Member.

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

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 an Other Health Care Facility or Professional (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 arranges, through contracts with other Providers, for the provision of any Covered Services.

Reconstructive Surgery is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. Reconstructive Surgery includes surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal craniofacial structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Reconstructive Surgery also includes breast reconstruction incident to mastectomy or lumpectomy to restore or achieve breast symmetry. This 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.

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

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. 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 Costs."

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

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

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of 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 at www.mycigna.com for details).

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;
- 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.

Specified Diabetic Services and Supplies are particular services and supplies provided or prescribed for the direct treatment of diabetes, including Diabetic Self-Management Training and Education, HbA1c, urinalysis, blood kidney function test for nephropathy, Metformin, diabetic retinal examination, test strips for blood glucose monitors; visual reading and urine test strips, lancets, syringes and needles. This does not include any other services or supplies not specifically listed here, even if such service or supply is provided or prescribed for the direct treatment of diabetes, nor will these listed services be considered a Specified Diabetic Service or Supply if provided for the treatment of any other diagnosis.

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

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Step Therapy is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including Specialty Medications. We 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 the applicant who has applied for and been accepted for coverage, and who is named as the Subscriber on the specification page.

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.

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

Tribal Health Program means, with respect to a Member who is a Native American or an Alaska Native only, an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

Virtual Care Service is a suite of medical Covered Services delivered through audio, video and secure internet-based technologies. Includes diabetic counseling, through Virtual means.

We/Us/Our is Cigna HealthCare of Illinois, Inc. (Cigna).

You, Your, and Yourself is the Subscriber who has applied for, and been accepted for coverage, and is named as the Subscriber on the specification page.

Who Is Eligible For Coverage?

Eligibility Requirements

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

- You are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and are reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; and
- You are a resident of the state of Illinois; and
- You live in the Enrollment Area in which You are applying, and intend to continue living there for the entire period for which enrollment is sought; and
- You are not incarcerated other than incarceration pending the disposition of charges; and
- You do not reside in an Institution; and
- You have submitted a completed and signed application for coverage and have been accepted in writing by Us.

The Subscriber must notify Us of all changes that may affect any Member's eligibility under this EOC.

Other Members may include the following Family Member(s):

- Your lawful spouse or partner to a civil union who lives in the Enrollment Area.
- Your children who live in the Enrollment Area and have not yet reached age 26.

  Your own, Your spouse's or Your partner to a civil union's **Newborn children** are automatically covered from the moment of birth for the first 31 days of life. To continue coverage past that time You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the date of birth, and pay any additional Premium. Coverage for a newborn dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth.

  An **adopted child,** including a child who is placed with You for adoption, is automatically covered for 31 days from the date of 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 a Family Member by applying for his or her enrollment as a Family Member within 60 days of the date of adoption, and pay any additional Premium. Coverage for an adopted dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.

  If a court has ordered a Subscriber to provide coverage for an eligible child (as defined above) coverage will be automatic for the first 31 days following the date on which the court order is issued.
  To continue coverage past that time You must enroll the child as a Family Member by applying for his or her enrollment as a Family Member within 60 days of the court order date, and paying any additional Premium. Court-ordered coverage for a dependent child enrolled within 60 days of the court order will be retroactive to the date of the court order.
- Your stepchildren who live in the Enrollment Area and have not yet reached age 26.
- Your unmarried military veteran dependent who has not yet reached age 30 if the veteran (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible, the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

- Your own, Your spouse's, or Your partner to a civil union's unmarried 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 Member 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 enrolled as a Family Member under this EOC who resides outside of the Service Area is entitled to receive, while outside the Service Area, only Emergency Services for Emergency Medical Conditions.

When Can I Apply?

Application to Enroll or Change Coverage

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

The Annual Open Enrollment Period and special enrollment period are explained below.

Annual Open Enrollment Period

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

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

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

Special Enrollment Periods

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

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

Triggering events for a special enrollment period 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 Alaska 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 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 (QHP) 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 QHP. 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 a new QHP as a result of a permanent move (including a move outside the Enrollment Area of the individual's current plan); or
- An eligible individual newly gains access to an employer sponsored individual coverage health reimbursement account (ICHRA); or
- An eligible individual newly gains access to a qualified small employer health reimbursement arrangement (QSEHRA).

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; or
- 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; or
- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Triggering events for a special enrollment period ON Marketplace are:

- An eligible individual, and any dependent(s), loses his or her minimum essential coverage, pregnancy-related Medicare/Medicaid coverage, or medically needy coverage (only once per Calendar Year), or the qualified individual or dependent is enrolled in any non-calendar year group or individual health insurance coverage (even if they have the option to renew such coverage). The date of the loss of minimum essential coverage, pregnancy-related coverage, or medically needy coverage is the last day the individual would have coverage under the plan. The date of loss of non-calendar year insurance is the last day of the plan or policy year; or
- An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours; or
- An eligible individual gaining or becoming a dependent through marriage (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 Alaska 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 eligible 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; or
- 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 qualified health plan (QHP) when they satisfy the Marketplace's citizenship requirement or are released from incarceration; or
- An eligible individual's enrollment or non-enrollment in a QHP 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 QHP 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% of the federal poverty level (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 a new QHP 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; or
- 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 Annual Open Enrollment Period has ended or more than 60 days after a qualifying life event; or
- 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; or
- An eligible individual newly gains access to an employer sponsored individual coverage health reimbursement account (ICHRA); or
- An eligible individual newly gains access to a qualified small employer health reimbursement arrangement (QSEHRA).

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; or
- 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; or
- In the case of untimely notice of a triggering event, the exchange must provide the earliest effective date that would have been available based on the applicable triggering event.

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; or
- 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 Requirements 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 Family Member(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 Family Member(s) would become ineligible due to age or no longer qualify as dependents for coverage under this EOC, except for the Subscriber's failure to pay Premium, that Family Member has the right to continuation of his or her insurance. Coverage will be continued if the Family Member exercising the continuation right notifies Cigna and pays the appropriate monthly Premium within 60 days following the date this EOC would otherwise terminate. In such a case, coverage will continue without evidence of insurability.

How the EOC Works

Note: Services performed by a Non-Participating (an Out-of-Network) Provider are not covered under this EOC except for Emergency Services.

Benefit Schedule

The benefit schedule shows the Individual and Family Deductible and Out-of-Pocket Maximums, and the maximum Covered Expense for each type of benefit.

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

In addition, no benefits are payable unless the Member receives services from a Participating Provider, except as indicated below under "Special Circumstances."

Participating Hospitals, Participating Physicians and Other Participating Providers

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

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

Special Circumstances

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

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

- **Emergency Services**
  Covered Expenses incurred for the treatment of an Emergency Medical Condition provided in the emergency department of a Non-Participating Hospital are paid 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**
  Covered Expenses for non-emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the benefit schedule in the following cases:
    - when you have a referral from your Participating (PCP) to a Non-Participating Provider; or
    - for any other reason We determine it is in your best interests to receive services from a Non-Participating Provider.

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

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

Please be Aware: Emergency Services provided by a Non-Participating Provider to You or Your Family Members will be reimbursed at no greater cost to you than if the services had been provided by a Participating Provider.

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 post stabilization services, 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.

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

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

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

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

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or urgent care requires notification to and Authorization by Cigna. 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 as soon as is reasonably possible. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to Us as soon as reasonably possible. Coverage for Emergency Services and urgent care received through Non-Participating Providers shall be limited to Covered Services to which you would have been entitled under this EOC, and you will be reimbursed for only the costs that you incur which you would have incurred if you received the services from a Participating Provider.

Deductibles

Deductibles are prescribed amounts of Covered Expenses the Member must pay before this EOC will pay your claims. Deductibles apply to all Covered Expenses as described in the "Definitions" section of this EOC, unless expressly stated otherwise in the benefit schedule. Deductibles do not include any amounts in excess of Allowed Expense, any penalties, or expenses that are not Covered Expenses.

Deductibles will be applied in the order in which a Member's claims are received and processed by Us, not necessarily in the order in which the Member received the service or supply.

Deductible

The Deductible is stated in the benefit schedule. The Deductible is the amount of Covered Expenses you must pay for **any** Covered Services (except as specifically stated otherwise in the benefit schedule) incurred from Participating Providers each Year before this EOC will pay your claims. There are two ways a Member can meet his or her Deductible:

- When a Member meets his or her Individual Deductible, that Member's benefits will be paid accordingly, whether any applicable Family Deductible is satisfied or not.
- If one or more Family Members are enrolled for coverage under this EOC, the Family Deductible will apply. Each Member can contribute up to the Individual Deductible amount toward the Family Deductible. Once this Family Deductible is satisfied, no further Individual or Family Deductible is required for the remainder of that Year.

Prescription Drug Deductible

A Prescription Drug Deductible, separate from the Deductible shown on the first page of the benefit schedule, may apply each Year only to Prescription Drugs and Specialty Medications covered by this EOC. Please refer to the definitions of "Individual Prescription Drug Deductible" and "Family Prescription Drug Deductible." The Prescription Drug Deductible is shown in the Prescription Drug Benefits section of the benefit schedule if Your plan includes a separate Prescription Drug Deductible.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount of Deductible, Copayment and Coinsurance each Family Member incurs in Covered Expenses in a Year.

- 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 In-Network Covered Services, you will no longer have to pay any Coinsurance or Copayment for medical or pharmacy services for Covered Expenses incurred In-Network 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.
- The Family Out-of-Pocket Maximum applies if You have a family plan and You and one or more of Your Family Member(s) are enrolled for coverage under this EOC. It is an accumulation of the Individual Covered Expenses, including Deductibles, Copayments and Coinsurance for medical and Prescription Drug Covered Services, paid by each Family Member for Covered Expenses during a Year. If You cover other Family Member(s), each Member's Covered Services accumulate toward the Family Out-of-Pocket Maximum. Each Family Member can contribute up to the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum for Covered Services has been met, the Family Members will no longer have to pay any Deductible, Coinsurance or Copayments for Covered Expenses incurred during the remainder of that Year. The amounts of the Individual and the Family Out-of-Pocket Maximum are described in the benefit schedule section of this EOC.

Special Limits

There may be limits applied to certain Covered Services in the form of an Annual maximum on the number of visits, days or events the EOC will cover for a specific type of service. The expenses you incur which exceed specific maximums described in this EOC will be your responsibility. Any special limits applicable to benefits in this EOC are described in the benefit schedule.

The expenses you incur which exceed specific maximums described in this EOC will be your responsibility.

Penalties

A penalty is an amount of Covered Expenses that is:

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

The following services require Prior Authorization. Penalties may be assessed against your Provider if your Provider fails to obtain Prior Authorization:

- Inpatient Hospital admissions and all other facility admissions,
- Free Standing Outpatient Surgical Facility Services,
- Certain outpatient surgeries and diagnostic procedures.

Failure to obtain Prior Authorization prior to receiving care may result in services not being covered or a reduction of benefits up to $1,000, whichever is less, regardless of the circumstances or Medical Necessity.

Penalties are applied before this EOC pays claims.

Comprehensive Benefits: What the EOC Pays For

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

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

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

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

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

Note: Services from an Out-of-Network (Non-Participating) Provider are not covered except for Emergency Services.

If you are inpatient in a Hospital or Other Health Care Facility on the day your coverage begins, We will pay benefits for Covered Services that you receive on or after your first day of coverage related to that inpatient stay as long as you receive Covered Services in accordance with the terms of this EOC. These benefits are subject to any prior carrier's obligations under state law or contract.

Inpatient Services and Supplies at a Hospital or Free-Standing Outpatient Surgical Facility

For any eligible condition, this EOC provides indicated benefits for Covered Expenses for:

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

Payments of Inpatient Covered Expenses are subject to these conditions:

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

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

Inpatient Services at Other Health Care Facilities

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

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

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

Hospice Care

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 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.

Professional and Other Services

This EOC provides benefits for Covered Expenses incurred for:

- Services of a Physician, physician's assistant, registered surgical assistant or advanced practice nurse;
- Virtual Care Services;
- Services of an anesthesiologist or an anesthetist;
- Outpatient diagnostic radiology and laboratory services;
- Radiation therapy, chemotherapy and hemodialysis treatment;

- Surgical implants, except for cosmetic and dental;
- Surgical procedures for sterilization (i.e., vasectomy, and or tubal ligations);
- Cochlear implants;
- Allergy testing, treatment and injections.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products;
- Internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Durable Medical Equipment

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

- Are ordered by a Physician;
- Serve a medical purpose and are 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.

Medical and Surgical Supplies

The EOC includes coverage for medical and surgical supplies that are Medically Necessary, serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly, creams or lotions.

Ambulance Services

This EOC provides benefits for Medically Necessary Covered Expenses incurred for the following ambulance services:

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

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

Occupational Therapy

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

Physical Therapy

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

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

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

Speech Therapy

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

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

Naprapathic Services

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

Chiropractic Services

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

Massage Therapy Services

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

The term "visit" includes any outpatient visit to a Physician during which one or more Covered Services are provided.
Coverage is limited to therapy services that are restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or illness. Services are not covered when they are considered by the Cigna Medical Director to be custodial, training, educational or developmental in nature. Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury. Note: this provision does not apply to services for Habilitative Therapy

Pulmonary and Cardiac Rehabilitation Services

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

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

Habilitative Services

This EOC provides benefits for Covered Expenses designed to assist you in developing a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame and are payable as stated in the benefit schedule.

This EOC provides benefits for Covered Expenses incurred for the following Habilitative Services:

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

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

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

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 “Exclusions and Limitations: What Is Not Covered by This EOC” 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 Participating 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 interfere 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 mental health conditions by a prescriber or licensed therapist by means of Telepsychiatry.
- 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.

Psychiatric Collaborative Care Model

This plan provides benefits for Covered Services delivered through the psychiatric collaborative care model. Under IL law, "psychiatric collaborative care model" means the evidence-based, integrated behavioral health service delivery method, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and incudes, but is not limited to, the following elements:

1) care directed by the primary care team;
2) structured care management;
3) regular assessments of clinical status using validated tools; and
4) modification of treatment as appropriate.

Care delivered through the psychiatric collaborative care model is reimbursed on the same basis as any other treatment for Mental Health or Substance Use Disorder.

Dental Care

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

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

Pregnancy and Maternity Care

Coverage is provided for Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous or elective abortion and complications of pregnancy, and maternal risk for you and your Dependents, including pregnancy of dependent children. Coverage includes prenatal HIV testing when ordered by a, or under the supervision of a Physician.

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

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

Preventive Care Services

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

- Routine physical exams, including but not limited to the following preventive screenings and counselling:
  - Blood pressure screening;
  - Obesity screening and counseling;
  - Diet counseling for adults at higher risk for chronic disease;
  - Aspirin use for men and women of certain ages;
  - Sexually transmitted infections (STI) prevention;
  - Depression screening;
  - Alcohol misuse screening and counseling;
  - Tobacco use screening and cessation interventions for tobacco users;
  - Annual whole body skin examination for detection of skin cancer
- Annual Pap test.
- Screening by low-dose mammography for all women over age 35 as follows:
  - Baseline mammogram for women ages 35-39 and annual mammogram for women age 40 and older;
  - For women under age 40 with a family history of breast cancer or other risk factors, mammograms will be covered at an age and interval considered Medically Necessary;
  - Coverage includes both (a) a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches; and (b) a screening MRI when Medically necessary, as determined by a Physician.
  - Low-dose mammography screenings are covered at no cost, subject to the conditions above.

  For purposes of this benefit, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. With respect to this benefit, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- Prostate Cancer Screening, including Annual digital rectal examination and prostate-specific antigen test for males upon recommendation of a physician for:
  - asymptomatic men age 50 and over;
  - African-American men age 40 and over;
  - men age 40 and over with family history of prostate cancer.

- Lung Cancer Screening annually with low-dose computed tomography for adults age 55 and over who have a 30 pack/year smoking history, and currently smoke or have smoked within the past 15 years;
- Cholesterol screening for adults of certain ages or at higher risk;
- Type 2 diabetes screening for abnormal blood glucose for adults with high blood pressure and/or as part of a cardiovascular risk assessment in adults age 40 and over who are overweight or obese;
- HIV screening for everyone ages 15-65;
- HIV screening for all adults at higher risk, and syphilis screening for adults at higher risk;
- Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for persons who are at high risk of HIV acquisition;
- Hepatitis C screening for persons at high risk of infection;
- Abdominal aortic aneurysm screening for men who have ever smoked;
- Colorectal cancer screening for adults over age 45;
- Items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis and Varicella:
- Vaccine for shingles that is approved by the United States Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine in all its branches and the enrollee is 60 years of age or older;
- Fall prevention in older adults;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to:
    - Congenital hypothyroidism screening, hearing screening, hemoglobinopathies or sickle cell screening and Phenylketonuria (PKU) screening for all newborns;
    - Gonorrhea preventive medication for the eyes of all newborns;
    - The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary): Hepatitis A, Hepatitis B, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella, Haemophilus Influenzae Type B, Rotavirus and Inactivated Poliovirus;
    - any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.
    - Iron supplements for children ages 6 to 12 months at risk for anemia;
    - Development screening for children under age 3, and surveillance throughout childhood;
    - Oral health risk assessment for younger children;
    - Vision screening for all children, and medical history for all children throughout development;
    - Fluoride chemoprevention supplements for children without fluoride in their water source starting at age 6 months; primary care clinicians should apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption;

- Lead screening for children at risk for exposure, and tuberculin testing for children at higher risk of tuberculosis at the following ages as part of a well-child visit:
    - 0-11 months;
    - 1-4 years;
    - 5-10 years;
    - 11-14 years; and
    - 15-17 years;
- Behavioral assessments and blood pressure screenings for children of all ages;
- Autism screening provided without regard to the Covered Person's age
- Dyslipidemia screening for children at higher risk of lipid disorder;
- Height, weight and body mass index measurements;
- Obesity screening and counseling;
- Hematocrit or hemoglobin screening;
- Depression screening for adolescents;
- Alcohol and drug use assessment for adolescents;
- Cervical dysplasia screening for sexually active females;
- HIV prevention education and risk assessments annually in adolescents;
- HIV screening and sexually transmitted infections (STI) prevention and counseling for adolescents at higher risk;
- Tobacco use screening, and cessation interventions including education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents, for tobacco users;
- Skin cancer behavioral counseling for young adults, adolescents, children and parents of young children from age 6 months to 24 years.

- For women, including pregnant women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including but not limited to:
    - Well woman visits to obtain recommended preventive services;
    - BRCA counseling about genetic testing and breast cancer chemoprevention counseling for women at higher risk;
    - Gonorrhea screening for all women at higher risk;
    - Chlamydia infection screening for younger women and women at higher risk;
    - Screening for urinary incontinence;
    - Cervical cancer screening, HIV screening and counseling and sexually transmitted infections (STI) counseling for sexually active women;
    - HIV prevention education and risk assessment in women at least annually throughout their lifespan;
    - Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older;
    - Osteoporosis screening for women over age 60, depending on risk factors;

- Domestic and interpersonal violence screening and counseling for all women;
- Alcohol misuse screening and counseling;
- Tobacco use screening and cessation interventions for tobacco users, and expanded counseling for pregnant tobacco users;
- Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
- Folic acid supplements for women who may become pregnant;
- Low-dose aspirin (81 mg/day) after 12 weeks of gestation for women who are at high risk for preeclampsia;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Syphilis screening for all pregnant women or other women at increased risk;
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Anemia screening on a routine basis for pregnant women;
- Bacteriuria urinary tract screening or other infection screening for pregnant women;
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Screening for diabetes after pregnancy;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, including coverage of the rental of one breast pump per birth up to the purchase price as ordered or prescribed by a Physician for pregnant and nursing women.
- Clinical breast examination

Detailed information is available at: www.healthcare.gov/coverage/preventive-care-benefits

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

Second Surgical Opinion

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

Genetic Testing

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

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

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

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

Autism Spectrum Disorders

This EOC provides benefits for Covered Expenses for Members for Charges made for:

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

Treatment for Autism Spectrum Disorders shall include 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.

Except for inpatient services, upon request from Cigna and not more than once every 12 months, a Provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is Medically Necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, Cigna may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

Covered Services include:

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

- Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
  a) Self-care and feeding,
  b) pragmatic, receptive, and expressive language,
  c) cognitive functioning,
  d) Applied Behavior Analysis, intervention, and modification,
  e) motor planning, and
  f) sensory processing.

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, liver, lung, pancreas or intestinal, including 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 evaluation, preparation and delivery of the donor organ.
- The removal of the organ from the donor. Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a deceased or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

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 1-800-287-0539.

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 a 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 a Member is a donor.

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

Diabetes

Covered Services for Diabetes are covered on the same basis as any other medical condition. This EOC provides benefits for Covered Expenses including outpatient Diabetic Self-Management Training and education, Diabetic Equipment and Diabetic Pharmaceuticals & Supplies for the treatment of Type I Diabetes, Type 2 Diabetes, and Gestational Diabetes Mellitus.

Foreign Country Providers

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

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

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 Providers. A visit is defined as a period of 2 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by Providers 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 a Provider. 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 rehabilitative therapy services.
- The Member must be confined at home, in lieu of hospitalization, under the active supervision of a Physician.
- The home health agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care.

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

Mastectomy and Related Procedures

This EOC provides benefits for Covered Expenses for Hospital and professional services under this EOC 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.

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

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

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

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

Note: coverage will not be denied for a Member diagnosed with a fibrocystic breast condition solely because the Member has been diagnosed as having a fibrocystic breast condition.

Treatment for Temporomandibular Joint Dysfunction (TMJ)

Medical services for TMJ 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, including TMJ.

External Prosthetic Appliances and Devices

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

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

Coverage for External Prosthetic Appliances and Devices is limited to the most appropriate and cost effective alternative. This includes coverage for repair, maintenance or replacement of a covered Prosthetic Appliance or Device, unless replacement is required because of misuse or loss of the Prosthetic on the part of the Member.

Coverage is provided for custom foot Orthoses and other Orthoses.

- Only the following non-foot Orthoses are covered, when Medically Necessary, as follows:
  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 a 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.

Clinical Trials

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

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

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

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

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

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

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

Routine patient care costs do not include:

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

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

- there are not In-Network Providers participating in the clinical trial that are willing to accept the individual as a patient; or
- the clinical trial is conducted outside the individual's state of residence.

Bariatric Services

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

Blood and Blood Components

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

Breast Cancer Pain Medication and Therapy

Coverage is provided for all Medically Necessary pain medication and therapy related to the treatment of breast cancer. Pain therapy means therapy that is medically based and includes reasonably defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals. Benefits will also be provided for all Medically Necessary pain medication related to the treatment of breast cancer under the Prescription Drug section of this EOC.

Dental Procedures Hospitalization/Anesthesia

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

Diabetic Services and Supplies

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

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

Donated Breast Milk

This EOC includes coverage for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, if:

- the Member is an infant under the age of 6 months,
- a licensed medical practitioner prescribes the milk for the Member, and
- all of the following conditions are met:
  1) the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;
  2) the infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated;
  3) the milk has been determined to be medically necessary for the infant; and
  4) one or more of the following applies:
     A. the infant's birth weight is below 1,500 grams;

B. the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;

C. the infant has infant hypoglycemia;

D. the infant has congenital heart disease;

E. the infant has had or will have an organ transplant;

F. the infant has sepsis; or

G. the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the infant.

The EOC also provides coverage for pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a prescribing licensed medical practitioner, if:

- the Member is a child 6 months through 12 months of age,
- a licensed medical practitioner prescribes the milk for the Member, and
- all of the following conditions are met:
  1) the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;
  2) the child's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated;
  3) the milk has been determined to be medically necessary for the child; and
  4) one or more of the following applies:
     A. the child has spinal muscular atrophy;
     B. the child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
     C. the child has had or will have an organ transplant; or
     D. the child has a congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the child

Eosinophilic Gastrointestinal Disorder

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

Hearing Aids

Coverage is provided for hearing aids, cochlear implants and bone anchored hearing aids (osseointegrated auditory implants), to the limit shown in the Benefit Schedule. Maximum of 1 per ear every 24 months for adults and children. Dollar maximums do not apply.

Hearing Examination

Coverage is provided for routine pediatric hearing examinations.

Immune Gamma Globulin Therapy

Immune gamma globulin therapy will be covered without delay, discontinuation, or interruption when a Member is diagnosed with a primary immunodeficiency and the therapy is prescribed as Medically Necessary by a licensed Physician. Prior Authorization is required and upon the initial diagnosis the initial authorization should be for at least 3 months. Reauthorization may occur every 6 months thereafter. For Members who have been receiving immune gamma globulin therapy for at least 2 years with sustained beneficial response based on the treatment notes or clinical narrative detailing progress to date, reauthorization will be no less than 12 months unless a more frequent duration has been indicated by the prescribing Physician.

Infertility

Coverage is provided on the same basis as for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to: in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, intracytoplasmic sperm injection and Medically Necessary services for standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility.

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

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

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

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

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

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

Special Limitations
Infertility Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from you will be covered if you choose to use a surrogate.
2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.
3. Non-medical costs of an egg or sperm donor.
4. Travel costs for travel within 100 miles of your home or travel costs not Medically Necessary or required by Cigna.
5. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
6. Infertility treatment rendered to your dependents under age 18.

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

Oral Surgery

Coverage is provided for the services listed below:
1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.
5. anesthesia services administered by oral or maxillofacial surgeons when such services are rendered in the surgeon's office or an ambulatory surgical facility.

Orthognathic Surgery

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

Osteoporosis Services

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

PANDAS and PANS

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

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

Reconstructive Surgery

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

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

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

Treatment for Tick Borne Diseases

Covered Services for long-term antibiotic therapy, including Medically Necessary Office Visits, Prescription Drugs, and ongoing testing, for a Member with a tick-borne disease when determined to be Medically Necessary and ordered by a Physician.

Exclusions and Limitations: What Is Not Covered by This EOC

Excluded Services

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

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition .
2. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this EOC.
3. Services **not specifically listed as Covered Services** in this EOC.
4. Services or supplies that are **not Medically Necessary**.
5. Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures or Unproven Procedures**.
6. Services **received before the Effective Date of coverage**.
7. Services **received after coverage under this EOC ends**.
8. Services **for which you have no legal obligation to pay** or for which no charge would be made if you did not have a health plan or insurance coverage.
9. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Member does not claim those benefits.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) a Member **participating in the military service of any country**; (d) a Member **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of a Member's 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;** (f) a Member **being intoxicated,** as defined by applicable state law in the state where the Illness occurred **or under the influence of illegal narcotics or non-prescribed controlled substances** unless administered or prescribed by Physician.
11. Any **services provided by a local, state or federal government agency**, except when payment under this EOC is expressly required by federal or state law.
12. Any **services required by state or federal law to be supplied by a public school system** or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
14. **If the Member is eligible for Medicare** Part A, B, C or D, Cigna will provide claim payment according to this EOC minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this EOC.
16. 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; or.
- A facility or health care professional that provides remuneration to you, or to an organization from which you receive remuneration.

17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this EOC.
18. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
19. **Private duty nursing** except when provided as part of the home health care services or Hospice Services benefit in this EOC.
20. Inpatient room and board **Charges in connection with a Hospital stay primarily for environmental change or physical therapy.**
21. Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a Mental Health Disorder.
22. **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; acupuncture point injection therapy; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
23. 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.
24. **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
26. Inpatient room and board **Charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
27. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.
28. Services **ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility**, when that Physician or other Provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.
29. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this EOC.

30. **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
31. **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
32. **Any services covered under both this medical plan and an accompanying exchange-certified pediatric dental plan**, and reimbursed under the dental plan, will not be reimbursed under this plan.
33. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this EOC, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound. .
34. **Routine hearing tests** except as provided under Preventive Care.
35. **Gene Therapy** including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.
36. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this EOC under Pediatric Vision.
37. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
38. **Cosmetic surgery, therapy** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
39. **Aids or devices that assist with nonverbal communication**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as specifically stated in this EOC.
40. **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, **except** as otherwise stated in this EOC.
41. **Services and procedures for** redundant skin surgery including abdominoplasty/panniculectomy , removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty and blepharoplasty **.**
42. 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.
43. Any treatment, prescription drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
44. Fees associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
45. Blood administration **for the purpose of general improvement in physical condition.**

46. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot orthotic devices.
47. **External and internal power enhancements** or power controls for prosthetic limbs and terminal devices.
48. **Myoelectric prostheses** peripheral nerve stimulators.
49. **Electronic prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
50. **Prefabricated foot Orthoses**.
51. **Cranial banding/cranial orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
52. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
53. **Orthoses primarily used for cosmetic** rather than functional reasons.
54. **Non-foot Orthoses**, except **only** the following non-foot orthoses are covered when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;
    - Semi-rigid pre-fabricated and flexible Orthoses; and
    - Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
55. Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Member has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
56. **Routine physical exams or tests** that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this EOC.
57. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
58. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna.
59. **Nutritional counseling or food supplements**, except as stated in this EOC.
60. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the Covered Services section of this EOC. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this EOC.

61. **Physical, and/or Occupational Therapy/Medicine** except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under ”Rehabilitative Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy)” in the section of this EOC titled “Comprehensive Benefits: What the EOC Pays For.”
62. All **Foreign Country Provider Charges** are excluded under this EOC except as specifically stated under “Foreign Country Providers” in the section of this EOC titled “Comprehensive Benefits: What the EOC Pays For.”
63. **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, a systemic condition, Injury or symptoms involving the feet. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
64. **Charges for which We are unable to determine Our liability** because the Member failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
65. Charges for the **services of a standby Physician**.
66. Charges for **animal to human organ transplants**.
67. **Claims received by Cigna after 15 months from the date service was rendered**, except in the event of a legal incapacity.

Prescription Drug Benefits

Pharmacy Payments

For Definitions associated with Prescription Drug Benefits, refer to the ”Definitions” section of this EOC. Prescription Drug Benefits are subject to the provisions within this section, and all other EOC provisions.

Covered Prescription Drugs and Related Supplies purchased at a Pharmacy are subject to the Deductible or Prescription Drug Deductible and once the Deductible is satisfied, subject to any applicable Copayments and/or Coinsurance shown in the benefit schedule. For additional information on the Deductible and the separate Prescription Drug Deductible, please refer to the “Definitions” section of the EOC.

Cigna will apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses You or Your Family Member(s) incur for covered Prescription Drugs or Related Services, or drugs obtained through Prior Authorization, Step Therapy or an exceptions and appeals process covered under this EOC, to any applicable Deductibles, Maximum Out-of-Pocket, Copayment, or Coinsurance.

Cigna's Prescription Drug List is available upon request by calling the customer service number on your ID card or at www.cigna.com/ifp-drug-list**.**

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.

For immunosuppressant drugs, if the prescribing Physician has indicated on the Prescription Order "may not substitute", a pharmacist may not interchange another immunosuppressant drug or formulation without notification and the documented consent of the prescribing Physician and the Member, or the parent or guardian if the Member is a child, or the spouse of the Member who is authorized to consent to the treatment of the Member. This does not apply to medication orders issued for immunosuppressant drugs during in-patient care in a licensed Hospital.

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.

Cigna’s Specialty Pharmacy

Accredo, Cigna's specialty Pharmacy, is available to fill and ship Specialty Medications used to treat complex conditions. Accredo’s team of specialty-trained pharmacists and nurses provide personalized care and support to manage your therapy.

When you use Cigna's specialty Pharmacy for your Specialty Medications, you receive personalized care and support such as: 24/7 access to pharmacists and nurses with experience and training in complex conditions, counseling, help managing side effects and one-on-one guidance from a clinician on how to administer your Specialty Medication. Some Specialty Medications may be eligible for copay assistance programs for which a dedicated team can assist you. The specialty Pharmacy also allows you several choices on how you want to connect with them – by text, phone and/or online resources.

The specialty Pharmacy makes it convenient for you to get your Specialty Medications by working with your Physician to obtain Prior Authorization, if required. They also schedule and ship your Specialty Medications quickly and with special handling, such as refrigeration. All necessary supplies are also included at no extra cost, such as, syringes or a sharps container.

To make sure you don't miss any doses of your Specialty Medication they will send you refill reminders and real-time updates once your medication has shipped.

You or your Physician can call Accredo, Cigna's specialty Pharmacy, at 877-826-7657 to talk with a representative.

Prescription Drugs Covered under the Medical Benefits

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

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 Accredo, Cigna's specialty Pharmacy, or through Cigna's home delivery Pharmacy, Express Scripts in order for that drug to be covered. If you have questions about where your Physician purchased 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 www.mycigna.com account, and
- view the Cigna Prescription Drug List at 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

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 Other 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 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.

Split Fill Dispensing Program

This program applies for the first 30 days when you start a new therapy on certain Limited Distribution Drugs and Specialty Prescription Drugs. The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply of your Prescription Order for certain drugs filled at Accredo or Express Scripts, Our home delivery pharmacy instead of the full Prescription Order. You pay half the 30-day Cost-Share for this initial 15-day supply, and would be responsible for the other half of the 30-day Cost Share if an additional 15-day supply is provided. The therapeutic classes of Prescription Drugs that are included in this program are determined by Cigna and will be managed for continuation in this program as new clinical guidelines and dispensing experience dictates.

Prescription Drug List Management

The Prescription Drug List is managed by the Business Decision Team, which makes, subject to the P&T Committee's review and approval of the Prescription Drug List, coverage tier placement decisions of Prescription Drugs or Related Supplies and/or applies utilization management requirements to certain Prescription Drugs or Related Supplies. Your EOC's coverage tiers may contain Prescription Drugs or Related Supplies that are Generic Drugs, Brand Name Drugs or Specialty Medications. Placement of any Prescription Drug or Related Supplies in a specific tier, and application of utilization management requirements to a Prescription Drug, depends on a number of clinical and economic factors. Clinical factors include, without limitation, the P&T Committee's evaluations of the place in therapy, or relative safety or relative efficacy of the Prescription Drug or Related Supplies, and economic factors include, without limitation, the cost and/or available rebates for Prescription Drugs or Related Supplies. Whether a particular Prescription Drug or Related Supplies is appropriate for You or any of Your Family Member(s), regardless of its eligibility coverage under Your EOC, is a determination that is made by You (or Your Family Member) and the prescribing Physician.

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

As a result of coverage changes, you may be required to pay more or less for that Prescription Drug or Related Supply, or try another covered Prescription Drug or Related Supply. Please access www.mycigna.com through the Internet or call Customer Service at the telephone number on your ID card for the most up-to-date coverage tier status, utilization management, or other coverage limitations for Prescription Drugs or Related Supplies.

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 You or Your Family Members by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

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

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 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 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 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.

What Is Covered

- 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.
- Pharmaceuticals to aid smoking cessation in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force.
- Insulin (no prescription required); syringes; injection aids, blood glucose monitors, blood glucose monitors for the legally blind; glucose test strips; visual reading ketone strips; urine test strips; lancets; oral hypoglycemic agents; Glucagon emergency kits and alcohol swabs.
- For prescription insulin drugs covered by this EOC, the cost share amount you are required to pay for a 30 day supply will be capped so that the amount you are required to pay for a covered prescription insulin drug will not exceed $100 dollars per 30-day supply.

- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- Medically Necessary pain medication related to the treatment of breast cancer.
- All non-infused compound Prescriptions that contain at least one FDA approved Prescription ingredient compounded from an FDA approved finished pharmaceutical product and are otherwise covered under the Prescription benefits, **excluding** any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA.
- 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 Participating Pharmacy.
- Medically Necessary fertility drugs in connection with the diagnosis and/or treatment of infertility with a written prescription
- Biological Drugs
- Prescriptions for opioid antagonist drugs for medically assisted treatment (MAT) of opioid use disorder do not require Prior Authorization, Step Therapy, dispensing limits or lifetime limits.
- At least one intranasal opioid reversal agent drug for initial prescription of opioids with dosages of 50 MME or higher.
- Prescription topical anti-inflammatory drugs approved by the FDA for acute and chronic pain.
- Inhalers prescribed for asthma or other life-threatening bronchial ailments will be allowed to be refilled prior to the time a refill may otherwise be obtained if Medically Necessary and ordered by a treating physician
- Prescription topical eye medication prescribed to treat a chronic condition of the eye will be allowed to be refilled prior to the last date of the prescribed dosage period and after at least 75% of the predicted days of use, when the prescribing Physician indicates on the original Prescription that refills are permitted and that early refills requested by the Member do not exceed the total number of refills prescribed.
- Prescription opioid antagonist medications, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist are covered under this EOC. The coverage includes refills for expired or utilized opioid antagonists. For the purposes of this benefit, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.
- Cigna will provide for the Synchronization of Prescription Drug refills at least once per Year if all of the following conditions are met:
    - the Prescription Drugs are on the Prescription Drug List, covered by the plan clinical coverage policy or have been approved through the Prescription Drug List exceptions process;
    - are medications You take on an ongoing basis and have refill quantities available at the time of Synchronization;
    - are not narcotics (Schedule II, III, or IV controlled substances);
    - all of the drug utilization management criteria have been met;
    - the drugs are of a formulation that can be safely split into short-fill periods to achieve Synchronization; and
    - the Prescription Drugs do not have special handling or sourcing needs as determined by the Plan that require a single, designated pharmacy to fill or refill the Prescription.
- Cigna will only impose one Copay for the dispensing of the Synchronized Prescription Drugs that equal the prescribed dosage for those drugs. The Copay will apply to each 30 day supply. All dispensing fees

will be based on the number of Prescriptions filled or refilled. Cigna will provide reimbursement forms for the additional Copay if the override is not in place prior to filling the Prescription.

- Cigna will provide coverage for Medically Necessary epinephrine injectors and the related auto injectors for persons 18 years of age or under.

Conditions of Service

The Drug or medicine 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 Member's 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.

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;
- Any 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;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this 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;
- Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido and/or sexual desire;
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;

- Any drugs that are Experimental or Investigational or Unproven as described in this EOC; except as specifically stated in the sections of this EOC titled “Clinical Trials,” and any benefit language concerning “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 inserted by the Physician are covered under the EOC’s medical benefits;
- Prescription and nonprescription 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 prenatal 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, drugs used to control perspiration and fade cream products;
- Medications used for travel prophylaxis, except anti-malarial drugs;
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies 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 the Member while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- 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;
- 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.

Limitations

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

- Up to a 90-day supply, at a 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 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 benefit schedule).

- Tobacco cessation medications that are 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.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Supplemental Drug Discount program

You are responsible for paying 100% of the cost for any Prescription Drugs or Related Supplies excluded by this plan. However, the Supplemental Drug Discount Program allows participating pharmacies to charge Members the discounted cost of non-covered Prescription Drugs and Supplies. This means you will pay 100% of the discounted cost, rather than the full cost, of Prescription Drugs and Supplies the plan does not cover. Please Note: the out-of-pocket costs that You and Your Family Member(s) pay for any Prescription Drugs or Related Supplies the plan does not cover will not be applied to the Member's Deductible or Out-of-Pocket Maximum.

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

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

Prior Authorization

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

Step Therapy

Step Therapy is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including without limitation, 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 similar 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 http://www.cigna.com/ifp-drug-list. To obtain Step Therapy Authorization, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

We will not limit or exclude coverage for a drug approved by the USFDA by requiring that You first fail to successfully respond to a different drug or prove a history of failure of the drug, as long as the use of the drug is consistent with best practices for the treatment of stage 4 advanced metastatic cancer and is supported by peer-reviewed medical literature.

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 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 drug brochure at www.mycigna.com, or call the toll-free customer service number on the back of 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 66301
St. Louis, MO 66301-6301
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**.**

Pediatric Vision Benefits for Care Performed by an Ophthalmologist or Optometrist

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

Pediatric Vision Benefits

Please be aware that the pediatric vision network is different from the network of your medical benefits.

Covered pediatric vision benefits are subject to any applicable Coinsurance shown in the benefit schedule, where applicable.

Covered Services

Covered Services for a Member, 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 prescriptions 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%. The cost share for non-collection frames is 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 aphakia; as determined and documented by your vision provider. Contact lenses fitted

for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction are not covered.

- Low Vision Coverage -Supplemental professional low vision services and aids are covered in full once every 12 months for a Member with partial sight, or whose sight is not fully correctable with surgery, pharmaceuticals, contact lenses or glasses. There are various low vision aids, such as the bioptic telescope, which can aid the Member with their specific needs.

Some Cigna vision network eye care professionals may not offer these services. Please check with your eye care professional first before scheduling an appointment.

Pediatric Vision Care Exclusions

- Services not provided by a Cigna vision in-network provider.
- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges in excess of the usual and customary charge for the Service or Material.
- Charges incurred after the EOC ends or the Member's coverage under the EOC ends, except as stated in the EOC.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "Covered Services" 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 Services" 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, or to get a claim form, the Member should visit www.**mycigna.com** and use the link on the vision coverage page, or if You or Your Family Member(s) have any questions about the pediatric vision benefit, call the toll-free customer service using the toll-free customer service number on the back of your ID card.

General Provisions

Third Party Liability

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

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

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

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

Alternate Cost Containment Provision

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

COORDINATION OF BENEFITS

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

Definitions

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

Plan

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

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

- Medical benefits coverage under any form of group or individual automobile insurance.

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

Primary Plan
The plan that pays first as determined by the Order of Benefit Determination Rules below.

Secondary Plan
The plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced based on the benefits under the Primary Plan.

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

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

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

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

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

- The plan that covers you as an enrollee or an employee shall be the Primary Plan and the plan that covers you as a dependent shall be the Secondary Plan;
- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the Calendar Year as an enrollee or employee;
- If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
    - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    - then, the plan of the parent with custody of the child;
    - then, the plan of the spouse of the parent with custody of the child;
    - then, the plan of the parent not having custody of the child; and
    - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's dependent) shall be the Primary Plan and the plan that covers you as a laid-off or retired employee (or as that employee's dependent)

shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- The plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that covers you is issued out of the state whose laws govern this plan, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

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

Effect on the Benefits Payable

- If this plan is the Primary Plan, the amount this plan pays for Covered Expenses will be determined without regard for the benefits payable under any other plan.
- If this plan is the Secondary Plan, the amount this plan pays for Covered Expenses is the Allowable Expense less the amount paid by the Primary Plan during a Claim Determination Period.

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

Recovery of Excess Benefits

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

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information We request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

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 Allowed Expense for a Non-Participating Provider.

When You Have a Complaint or Appeal (For Illinois residents)

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

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

Start with Customer Service

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

Cigna
Individual Services
PO Box 182223
Chattanooga TN 37422

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

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

Appeals Procedure

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

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

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

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

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

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

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

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

Expedited Appeal

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

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

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

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

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

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

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

(i) reasons for the determination,

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

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

External Independent Review Procedure

External Review Procedure

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

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

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

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

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

Expedited External Review Procedure

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

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

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

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

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

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

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

Ineligible for External Review:

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

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

Ineligible for Expedited External Review:

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

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

Complaints or Assistance

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

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided to you, your designee or guardian, your Primary Care Physician and the ordering health care Provider, in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the denial decision; (3) reference to the specific EOC provisions on which the decision is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process; (7) Cigna's address, toll-free phone number, fax number and appeal email address; (8) information that is specific and limited to appeals and external review procedures for your plan; (9) information about the one level of appeal that is available; (10) the date of the adverse determination and, if applicable, the date of the final adverse determination; and (11) upon exhaustion of internal appeals by the Member, the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that you have 4 months from the date of the letter to file an external review. A final notice of adverse determination will include a discussion of the decision.

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

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

Relevant Information

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

Legal Action

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

Binding Arbitration

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

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30 day period and the 2 arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a 3rd arbitrator in accordance with these requirements. In the case of an arbitration, the arbitrator shall not have authority to conduct a Class Action, combine or aggregate similar claims of an entity or person not a party to this EOC, or make an award to any person or entity not a party to this EOC.

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

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

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

Terms of the EOC

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

- **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.

- **Circumstances Beyond Our 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 Covered Services, We will make a good faith effort to provide or arrange for the provision of the Covered Service taking into account the impact of the event.

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

- **Grace Period:**
  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 receive advanced premium tax credit (APTC), there is a grace period of thirty-one (31) days during which Premiums may be paid without loss of coverage of any Premium due after the first Premium. 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 advanced premium tax credit (APTC), 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 EOC only in the event of any of the following:

  1. You fail to pay Your Premiums as they become due or by the end of the last day of the 31 day grace period for plans not purchased from a Marketplace or the 90 consecutive day grace period for plans purchased from a Marketplace.
  2. On the first of the month following Our receipt of Your written notice to cancel.
  3. When You become ineligible for this coverage.
  4. If You have committed, or allowed someone else to commit, any fraud or deception in connection with this EOC or coverage.
  5. Material violation of the terms of the EOC.
  6. When We cease to offer policies of this type to all individuals in Your class. In this event, Illinois 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 an Member.
  7. When We cease offering any plans in the individual market in Illinois, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
  8. When the Subscriber no longer lives in the Enrollment Area.
  9. In the event of entry of a final judgment by a court declaring all or part of the Patient Protection and Affordable Care Act (P.L. 111-148) invalid, unconstitutional, or otherwise ineffective, and the state not providing alternative and sufficient means of funding advanced-premium tax credits, this EOC shall be subject to cancellation consistent with applicable federal and state law.

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

- **Modification of Coverage:**

  We reserve 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. We will send written notice and the change will become effective on the date shown in the notice or on the next scheduled Premium due date thereafter. Payment of the Premiums will indicate acceptance of the change.

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

  1. a complete description of the action to be taken,
  2. a specific description of the type of coverage affected,
  3. the total number of covered lives affected,
  4. a sample draft of all letters being sent to the plan sponsors, participants, beneficiaries, or covered individuals,
  5. time frames for the actions being taken,

6. options the plans sponsors, participants, beneficiaries, or covered individuals may have available to them under this Act, and
7. any other information as required by the Department.

- **Additional Programs:**
  We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to You and Your Family Members for the purpose of promoting the general health and well-being of You and Your Family Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Members. Contact Us for details regarding any such arrangements.

- **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.

- **Renewal:**
  This EOC renews on a Calendar Year basis.

- **Fraud:**
  If a Member 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.

- **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 made so that We will be paid the Premium rate appropriate for the true age of the Member.

- **Certificate of Creditable Coverage:**
  If coverage under this EOC terminates for any Member, We will furnish to that person a Certificate of Creditable Coverage containing the information required by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. A Member may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the EOC and for 24 months following termination of coverage. To obtain a certificate call the toll-free customer service number on the back of your ID card. Such a certificate may help the Member to obtain future coverage. However, Cigna is responsible only for the accuracy of the information contained in any certificate We prepare. We have no responsibility for the determinations made by any other health insurance issuer with respect to any coverage it provides, including whether or not, or to what extent, the information contained in the certificate is relevant to the other health insurance issuer's actions.

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

- **Conformity with State and Federal Statutes:**
  If any provision of this 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.

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

- **The Member(s) are the only persons entitled to receive benefits under this EOC.** FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS EOC AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

- **The Effective Date of this** EOC is printed on the Cigna identification card and on the EOC specification page.

- **Identification Cards** are issued by Cigna to Members are for identification only. Possession of the card does not guarantee coverage. To be entitled to coverage, the Member must be enrolled and eligible at the time of service.

- **The relationship between Cigna and Participating Providers** who are not employees of Cigna are independent contractor relationships. Such Participating Providers are not agents or employees of Cigna; and Cigna and its employees are not agents or employees of such Participating Providers. Cigna is not responsible for any claim for damages or injuries suffered by a Member while receiving care from any Participating or Non-Participating Provider.

- **Cigna will meet any Notice requirements by** mailing the Notice to the Member at the billing address listed in Our records. It is the Member's responsibility to notify Us of any address changes. The Member will meet any Notice requirements by mailing the Notice to:

  Cigna
  Individual Services
  P.O. Box 30028
  Tampa, FL 33630-3028

- **When the amount paid by Cigna exceeds the amount for which We are liable under this EOC,** We have the right to recover the excess amount from the Member unless prohibited by law.

- **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.

- **In order for a Member to be entitled to benefits under this EOC**, coverage under this EOC must be in effect on the date the expense giving rise to a claim for benefits is incurred. Under this EOC, an expense is incurred on the date the Member(s) receives a service or supply for which the Charge is made.

- **We will pay all benefits of this EOC directly to Participating Hospitals, Participating Physicians, and all other Participating Providers**, whether the Member has authorized assignment of benefits or not, unless the Member has paid the claim in full, in which case We will reimburse the Member. In addition, We may pay any covered Provider of services directly when the Member assigns benefits in writing no later than the time of filing proof of loss (claim), except for Foreign Country Provider claims. However, We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Family Member(s), You or Your Family Member(s) are responsible for reimbursing the Provider and Our payment to You will be considered fulfillment of Our obligation.

- **If We receive a claim from a Foreign Country Provider for an Emergency Medical Condition**, any eligible payment will be sent to the Member. The Member is responsible for paying the Foreign Country Provider. These payments fulfill Our obligation to the Member for those services.

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

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

- **Continuation of Care after Termination of a Provider whose participation has terminated.** Cigna will provide benefits to You or Your Family Member(s) at the Participating Provider level for Covered Services of a terminated Provider for the following special circumstances:
  - Ongoing treatment of a Member up to the 90th day from the date of the Provider's termination date.
  - Ongoing treatment of a Member who at the time of termination has been diagnosed with a Terminal Illness, but in no event beyond 9 months from the date of the Provider's termination date.

- **We will provide the Member with an updated list of local Participating Providers when requested.** If the Member would like a more extensive directory, or needs a new Provider listing for any other reason, please call Cigna at the number on the ID card and We will provide the Member with one, or visit our website, www.cigna.com.

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

- **If Member(s) were covered by a prior Individual Cigna EOC that is replaced by this EOC with no lapse of coverage,** benefits used under the prior EOC will be charged against the benefits payable under this EOC.

- **Cigna reserves the right 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 legislative act.

- **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.

Other Insurance With This Insurer

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

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

How to File a Claim for Benefits

Notice of Claim: There is no paperwork for claims for services from Participating Providers. You will need to show your ID card and pay any applicable Copayment; your Participating Provider will submit a claim to Us for reimbursement. Claims for Emergency Services from Non-Participating Providers can be submitted by the Provider if the Provider is able and willing to file on your behalf. If a Non-Participating Provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on your ID card.

Claim Forms: You may get the required claim forms from www.cigna.com under Health Care Providers, Coverage and Claims, or by calling Member Services using the toll-free number on your identification card.

Claim Reminders:

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

Proof of Loss: You must give Us written proof of loss within 15 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.

Assignment of Claim Payments:

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

We will recognize and consider any assignment made under the EOC, only if:

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

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Family Member(s),

You or Your Family Member(s) are responsible for paying the Non-Participating Provider and Our payment to You will be considered fulfillment of Our obligation.

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

Timely Payment of Claims: Benefits will be paid within 30 days after receipt of proof of loss. Should we determine that additional supporting documentation is required to establish responsibility of payment, we shall pay benefits within 30 days after receipt of proof of loss. If we do not pay within such period, we shall pay interest at the rate of 9 percent per year from the 30th day after receipt of such proof of loss to the date of late payment.

Payment of Claims: Any benefits payable under this EOC for Covered Services provided by a Participating Provider will be paid directly to that Participating Provider unless you direct otherwise, in writing, by the time proofs of loss are filed. Any benefits payable under this EOC for Covered Services provided by a Non-Participating Provider will be paid directly to you unless you direct otherwise, in writing, by the time proofs of loss are filed. In the event of your death, We will issue any benefits payable to you to the beneficiary of your estate as determined by applicable law.

Claim Determination Procedures Under Federal Law (Provisions of the laws of this state may supersede.)

Procedures Regarding Medical Necessity Determinations

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

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

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

Pre-service Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize the Member's life or health, their ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Member's health condition, cause them severe pain which cannot be managed without the requested services, Cigna will

make the pre-service determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify the Member or their representative of an expedited determination within 72 hours after receiving the request.

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

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

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

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

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

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

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a description of any additional material or information necessary to

perfect the claim and an explanation of why such material or information is necessary; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, Experimental treatment or other similar exclusion or limit; (6) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Premiums

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 charges incurred by You are received by Cigna.

Your Premium may change 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 Family Members 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.