Cigna HealthCare of North Carolina, 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 North Carolina, Inc.
INDIVIDUAL AND FAMILY EVIDENCE OF COVERAGE
Cigna Connect 0-3A

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

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

Cigna
Individual Services
P.O. Box 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 North Carolina, Inc. (referred to herein as Cigna) based on the information You provided in Your application. If You know of any misstatement in Your application, You should advise the Company immediately regarding the incorrect information; otherwise, Your EOC may not be a valid contract.

THIS IS A LEGAL CONTRACT
Read Your Evidence Of Coverage Carefully

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

Important Cancellation Information
Please Read The Provision Entitled, "Cancellation", Found On Page 88.

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. If your plan requires the designation of a Primary Care Physician, 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.

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Introduction

About This EOC

Your medical coverage is provided under an Evidence of Coverage (EOC) issued by Cigna HealthCare of North Carolina, 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, FOSTER OR ADOPTED CHILDREN ADDED WITHIN 60 DAYS AFTER BIRTH OR PLACEMENT IN YOUR HOME), 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.

PLEASE NOTE RESCISSION OF COVERAGE IS SUBJECT TO THE INTERNAL APPEALS PROCESS

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 as stated in the Special Circumstances provisions section of this EOC.

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

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

Cigna will not limit either of the following:
(1) A Participating Provider's ability to discuss with a Member the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.
(2) The Participating Provider's professional obligations to patients as specified under the provider's professional license.

If You Need a Specialist

Your PCP is important to the coordination of your care. While this EOC does not require referrals to visit specialists, if you need specialty care you are encouraged to work with your PCP, who can coordinate your care and assist you in selecting a specialist appropriate for your care.

The referral system can be used to keep your PCP involved in and apprised of all of your health care needs. If you receive Covered Services from a specialist in the Policy's network without a referral, you will not be subject to a penalty, and the claims for those Covered Services will be processed according to the applicable In-Network level of benefits.

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 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 60 days 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.

Also, in the event a Member was determined to be terminally ill at the time of a Provider's termination of participation in the network, and that Provider was treating the terminal illness prior to his or her termination, the period of continuity of care shall extend for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

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

Confined to a Hospital

If you are confined in a Hospital on the Effective Date of your coverage, you must notify Us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you 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.

If on your Effective Date of coverage you are in your second or third trimester of pregnancy, the period of continuity of care under the treatment of the Provider treating you prior to your Effective Date of coverage shall be through 60 days of post-partum care from that Provider.

If on your Effective Date of coverage, you have been diagnosed with and are under treatment for a terminal illness, the period of continuity of care shall extend for the remainder of your life with respect to care from the Provider who was treating the terminal illness prior to your Effective date, for care directly related to the treatment of the terminal illness or its medical manifestations.

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."

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. and as stated in the Special Circumstances section. For additional details see the "How The EOC Works" section of Your EOC.

NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance percentage or Copayment amount because the actual Provider charges may not be used to determine plan and Member payment obligations.

The following services are covered as mandated by North Carolina: Lymphedema, emergency care, minimum inpatient stay following delivery of a baby, minimum benefits offered for alcoholism/drug abuse treatment, access to non-formulary drugs, hearing aids, bone mass measurement, contraceptives or devices, colorectal cancer screening, newborn hearing screening, ovarian cancer surveillance tests, prostate cancer screening, reconstructive breast surgery following a mastectomy, coverage for congenital defects and anomalies, clinical trials, anesthesia and hospital charges for dental procedures for certain individuals, diabetes, mental illness equity in benefits and minimum coverage requirement, coverage for certain off-label drug use for the treatment of cancer, TMJ dysfunction coverage, cardiac and pulmonary rehabilitation, orthotic device for positional plagiocephaly, organ donor search, sexual dysfunction, sterilization, blood services.

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.	 $0 $0
Coinsurance	50%
Out-of-Pocket Maximum **Individual** **Family**	 $2,850 $5,700

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
Prior Authorization Program	
Prior Authorization – Inpatient Services	**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.
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 selected outpatient procedures and services. Failure to do so may result in a penalty or denial of payment for services provided.
All Preventive Care Services Please refer to “Comprehensive Benefits: What the EOC Pays For” section of this EOC for additional details	0%

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
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 and Refraction for Children** 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** Low vision exam no more than once per year and no less than once per 5 years.	 0% 0% 0% per pair 0%
Physician Services **Office Visit** **Primary Care Physician** (PCP) **Specialist** (including consultant and second opinion services) Note: Office Visits for the evaluation and treatment of obesity are limited to a maximum of four (4) visits per Calendar Year	 $0 Copayment per visit $25 Copayment per visit

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 **Virtual Care Service from Participating Physicians other than Dedicated Virtual Care Physicians** (This benefit excludes any services that are delivered via telephone only.) Note: Any Prescription issued during a virtual visit is subject to all Prescription Drug Benefits, limitations and exclusions.	$0 Copayment per visit Same benefit as when service provided in person
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%

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 Maximums for Habilitative Services do not reduce maximums for rehabilitative services. Maximum does not apply to services for treatment of Autism Spectrum Disorders.	
Physical Therapy	50%
Occupational Therapy Combined limit 30 visits per Member per Calendar Year for Physical Therapy, Chiropractic Treatment and Occupational Therapy	50%
Speech Therapy Limit 30 visits per Member per Calendar Year	50%
Chiropractic Treatment	50%
Cardiac & Pulmonary Rehabilitation Maximum of 30 visits per Member, per Calendar Year, Cardiac and Pulmonary Rehabilitation combined. Limits based on Medical Necessity guidelines.	50%
Habilitative Services Maximums for rehabilitative services do not reduce maximums for Habilitative Services. Maximum does not apply to services for treatment of Autism Spectrum Disorders.	
Physical Therapy	50%
Chiropractic Treatment	50%
Occupational Therapy Combined limit 30 visits per Member per Calendar Year for Physical Therapy, Chiropractic Treatment and Occupational Therapy	50%
Speech Therapy Limit 30 visits per Member per Calendar Year	50%
Hearing Aids Limited to one hearing aid per hearing impaired ear every 36 months	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
Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD)	50%
Women's Contraceptive Services, Family Planning and Sterilization	0%
Male Sterilization	Copayment or Coinsurance applies for specific benefit provided
Maternity (Pregnancy and Delivery)/ Complications of Pregnancy	
Initial Office Visit to confirm pregnancy and subsequent prenatal visits billed separately from the "global" fee	PCP or Specialist Office Visit benefit applies
Prenatal services, Postnatal and Delivery billed as "global" fee	50%
Hospital Delivery	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

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
Inpatient Services at Other Health Care Facilities Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities Maximum of 60 days per Member, per Calendar Year for all facilities listed	50%
Home Health Care Services	50%
Durable Medical Equipment	50%
Prosthetics	50%
Hospice **Inpatient** **Outpatient**	 50% 50%
Dialysis **Inpatient** **Outpatient**	 Inpatient Hospital Services benefit applies 50%
Mental Health Disorder **Inpatient** (includes Acute and Residential Treatment) **Outpatient** (includes individual, group, intensive outpatient and partial hospitalization) Office Visit All other outpatient services	 Inpatient Hospital Services benefit applies PCP Office Visit benefit applies 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)	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.	50%
Specified Diabetic Services and Supplies	0%
Infertility Services	50%
Sexual Dysfunction Services	50%
Orthotic Device for Positional Plagiocephaly	50%
Diagnosis and Treatment of Lymphedemia	50%
Clinical Trials	50%
Bariatric Surgery **(See benefit detail in the section titled "What is covered" for covered procedures and other benefit limits which may apply)**	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: In addition to the cost-sharing amounts described below, you may be responsible for additional Charges including, but not limited to: (a) Charges for non-Covered Services and (b) Charges for services performed by Non-Participating Providers that are in excess of the Allowed Expense.	
Hospital Emergency Room		
Emergency Medical Condition	$500 Copayment per visit	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	$20 Copayment per visit	In-Network Cost Share applies
Non-Emergency Medical Condition	$20 Copayment per visit	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%

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: In addition to the cost-sharing amounts described below, you may be responsible for additional Charges including, but not limited to: (a) Charges for non-Covered Services and (b) Charges for services performed by Non-Participating Providers that are in excess of the Allowed Expense.	
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.** **ou 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.		
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.	$0 Copayment per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy. You pay a Copayment for each 30-day supply	$0 Copayment 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.	$12 Copayment per Prescription or refill 30-day supply - at any Participating Pharmacy or Up to a 90-day supply - at a 90 Day Retail Pharmacy. You pay a Copayment for each 30-day supply	$30 Copayment 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.	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 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% 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% 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 state and federal 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 North Carolina, 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®.

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.**

Complications of Pregnancy means medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, endometritis, and emergency cesarean section. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy**.**

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 certain Virtual Care Services.

Deductible means the amount of Covered Expenses that must be paid for Covered Services each Year before benefits are available under 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 Avery, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey, Bertie, Camden, Chowen, Currituk, Gates, Halifax, Hertford, Martin, Northampton, Pasquotank, Perquimans, Edgecombe, Greene, Nash, Pitt, Wayne, Wilson, Duplin, Onslow, Beaufort, Carteret, Craven, Dare, Hyde, Jones, Lenoir, Pamlico, Tyrell, Washington, Montgomery, Moore, Bladen, Cumberland, Harnett, Hoke, Richmond, Robeson, Sampson, Scotland counties in the state of North Carolina 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 North Carolina, 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 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.

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.

Grievance means a written complaint submitted by a covered person about any of the following:

- Cigna’s decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in this EOC.
- Claims payment or handling; or reimbursement for services.
- The contractual relationship between a covered person and Cigna.
- The outcome of an appeal of a Noncertification.

Habilitative Services are those services that are:

(i) 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,

(ii) covered health care services and devices that help a member keep, learn, or improve skills and functioning for daily living,

(iii) are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and

(iv) are individualized and there is documentation outlining quantifiable, measurable and attainable treatment goals.

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

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

Hospice Care Services means 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.

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.

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

Infusion and Injectable Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional. 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 or Dentally Necessary means the services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not primarily for the convenience of the Member, the Member's family, Physician or another Provider.

For Medically Necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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

Member means 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.

Noncertification means a determination by Cigna that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet Cigna's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services, and the requested service is denied, reduced, or terminated. A Noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in this EOC. A Noncertification includes any situation in which Cigna makes a decision about a covered person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under Your Plan is affected by that decision.

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.

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

Premium means the sum of money paid periodically to Cigna by You in order for You and Your 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 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 directly or indirectly 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.

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."

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

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

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

This definition excludes any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of 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 medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of Hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including Medically Necessary services and supplies to maintain stabilization until the Member is transferred.

Step Therapy is a type of Prior Authorization. Cigna may require a Member to follow certain steps before covering some Prescription Drugs and Related Supplies, including Specialty Medications. 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.

We/Us/Our is Cigna HealthCare of North Carolina, 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 North Carolina; 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 domestic partner who lives in the Enrollment Area.
- Your children who have not yet reached age 26.

  Your own, or Your spouse's or domestic partner's **Newborn children** are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as 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. If no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's birth, or the first date of coverage under this EOC whichever is later.

  An **adopted child,** including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as 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 no additional premium is required You must enroll the child, but no prior notification is required. Coverage would then be effective on the date of the child's birth, or the first date of coverage under this EOC whichever is later.

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

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 have not yet reached age 26.
- Your own, or Your spouse's or domestic partner'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 and not more frequently than annually after attaining age 26.

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. Under PPACA special enrollment period guidelines the qualified individual or enrollee may elect a coverage effective date of the first day of the month following the date of the event, OR elect a

regular effective date. If the qualified Individual or enrollee does not elect a delayed effective date then the "default" will be the date of birth for a newborn, adoption, or placement in the home for an adopted or foster child; 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.

Students Taking a Medically Necessary Leave of Absence

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

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

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

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, and as stated in the Special Circumstances section.

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.

- **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 – Network Exception**
  Covered Expenses for non-emergency, Medically Necessary services of a Non-Participating Provider will be paid according to the Participating Provider Cost Share shown in the benefit schedule in the following cases:
    - when those services are unavailable from a Participating Provider; or
    - when a Participating Provider cannot provide timely Covered Services; or
    - if a Member receives services at an In-Network facility and the Hospital based Providers are not In-Network Providers; or
    - for any other reason We determine it is in Your best interests to receive services from a Non-Participating Provider.

Coverage received through the Non Participating Provider is limited to:

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

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

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

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

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

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

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

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

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.

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 and as stated in the Special Circumstances section.

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.

Infertility

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

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;
- 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);
- 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.

Positional Plagiocephaly

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

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 to the nearest facility capable of handling the emergency.

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

This EOC provides benefits for Covered Expenses incurred for the following rehabilitative services:

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

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

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

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 you to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame.

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

Bariatric Surgery

This EOC provides benefits for Covered Expenses incurred for medical and surgical services:

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

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

The following items are specifically excluded:

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

Hearing Aid Coverage

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

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

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.

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.

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

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

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

Pediatric Dental Care Benefits

Pediatric dental care for Members less than 19 years of age are provided in the pediatric dental care policy in which the Member is enrolled. Pediatric dental care policy benefits are subject to all the terms and conditions of the pediatric dental care policy.

Pregnancy and Maternity Care

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

All comprehensive benefits described in this EOC are available for maternity services. Comprehensive Hospital benefits for routine nursery care of a newborn child are available so long as the child qualifies as an eligible dependent as defined in the section of this EOC titled “Who is Eligible for Coverage?”

The mother and her newborn child are entitled, under federal law, to inpatient Hospital coverage for a period of 48 hours following an uncomplicated vaginal delivery; and 96 hours following an uncomplicated delivery by cesarean section. We will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a Provider obtain Authorization for prescribing a length of stay that does not exceed the above periods. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. If a decision is made between a mother and doctor to discharge a mother or newborn child from inpatient care before the 48 or 96 hour time period, coverage for timely post-delivery care is available.

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

Preventive Care Services

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

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

Well Baby and Well Child Care

Covered Expenses include the following services for a Member:

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

Bone Mass Measurement Test

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

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

A Qualified Person means one who:

(a) is estrogen deficient and at clinical risk for osteoporosis or low bone mass;(b) is experiencing radiographic osteopenia anywhere in the skeleton;

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

(d) is having primary hyperparathyroidism;

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

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

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

Adult Preventive Care

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

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

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

- Charges for mammograms, including:
  - a baseline mammogram
  - a mammogram every other year
  - a mammogram every year if Medically Necessary and
  - the Physician’s interpretation of the laboratory results
- Prostate Specific Antigen (PSA) tests or equivalent tests for the presence of prostate cancer, and the Office Visit and physical examination associated with this test when ordered by the Member’s Physician or nurse practitioner;

- Charges for colorectal cancer examinations and laboratory tests for cancer for a non-symptomatic Member or for a Member who is: at high risk for colorectal cancer according to the most recently published guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

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 (medications used for travel prophylaxis, except anti-malarial drugs), employment, school or sports.

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.

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

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

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

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

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

Sexual Dysfunction Services

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

Reconstructive Surgery

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

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

Treatment for Temporomandibular Joint Dysfunction (TMJ)

Medical services for TMJ and other disorders of the bones and joints of the jaw, face, and head are covered on the same basis as any other medical condition. Dental services (i.e. dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums), or orthodontic services (i.e. braces and other orthodontic appliances) are not covered by this EOC for any diagnosis, 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 all routine patient care costs related to an approved clinical trial provided by a Participating Provider, including Phases I through IV, for a Member 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 and treatment of cancer or other life-threatening disease or condition and

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

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

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

The clinical trial must meet one of the following requirements:

1. Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials:
   i. An institute or center of the National Institutes of Health,
   ii. The Food and Drug Administration,
   iii. The Department of Veterans Affairs,
   iv. The Department of Defense,
   v. The Department of Energy,
   vi. The Centers for Disease Control and Prevention,
   vii. The Agency for Health Care Research and Quality,
   viii. The Centers for Medicare & Medicaid Services,
   ix. Cooperative group or center of any of the entities described in clauses (i) through (vi) or the Department of Defense or the Department of Veterans Affairs, or
   x. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
2. Be conducted under an Investigational new drug application reviewed by the Food and Drug Administration; or
3 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 Member who is not enrolled in a clinical trial, including the following:

- Services typically provided absent a clinical trial.
- Services required solely for the provision of the Investigational drug, item, device or service.
- 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.
- Reasonable and necessary care arising from the provision of the Investigational drug, device, item or service, including the diagnosis or treatment of complications.

For clinical trials, routine patient costs **do not** include:

1. the Investigational item, device, or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Nutritional Evaluation

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

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

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

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 or as shown in the Special Circumstances section .
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**, except routine patient care costs related to qualified clinical trials as described in this EOC.
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. Conditions caused by: (a) an **act of war (declared or undeclared) ,** this does not apply to an act of terrorism; (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**.
10. Any **services required by state or federal law to be supplied by a public school system** or school district.
11. 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.
12. **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.
13. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this EOC.
14. 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, directly or indirectly, or to an organization from which you receive, directly or indirectly, remuneration.

15. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this EOC.
16. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
17. **Private duty nursing** except when provided as part of the home health care services or Hospice Services benefit or when deemed Medically Necessary. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.
18. Inpatient room and board **Charges in connection with a Hospital stay primarily for environmental change or physical therapy.**
19. 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.
20. **Complementary and alternative medicine services, including but not limited to**: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
21. 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.
22. **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.
23. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
24. 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.
25. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.
26. 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.
27. **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.
28. **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction, except as specifically provided in this EOC.
29. **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.

30. **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.
31. **Routine hearing tests** except as provided under Preventive Care.
32. **Genetic screening**; except for the testing for the occurrence of BRCA gene (breast cancer related genetic marker) under federal preventative care for women, or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
33. **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.
34. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery and as specifically stated in this EOC under Pediatric Vision.
35. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
36. **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, foster or adopted child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
37. **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.
38. **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.
39. **Services and procedures for** redundant skin surgery including abdominoplasty/panniculectomy (except treatment of congenital anomaly), removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; rhinoplasty, blepharoplasty **regardless of clinical indications.**
40. 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.
41. All services related to In-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals, except as specifically stated in this EOC.
42. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
43. 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.

44. Blood administration **for the purpose of general improvement in physical condition.**
45. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot orthotic devices.
46. **External and internal power enhancements** or power controls for prosthetic limbs and terminal devices.
47. **Myoelectric prostheses** peripheral nerve stimulators.
48. **Electronic prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
49. **Prefabricated foot Orthoses**.
50. **Cranial banding/cranial orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
51. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
52. **Orthoses primarily used for cosmetic** rather than functional reasons.
53. **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.
54. Services primarily for **weight reduction or treatment of obesity**, except bariatric services for **morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes surgery, even if the Member has other health conditions that might be helped by a reduction of weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat weight control or weight reduction.
55. **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.
56. 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.
57. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna.
58. **Nutritional counseling or food supplements**, except as stated in this EOC.
59. **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, except for the treatment of diabetes, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this EOC.

60. **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."
61. 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."
62. **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.
63. **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.
64. Charges for the **services of a standby Physician**.
65. Charges for **animal to human organ transplants**.
66. **Claims received by Cigna after 18 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 shown in the benefit schedule, 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, please refer to the “Definitions” section of the EOC.

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.

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

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

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

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

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.
- Orally administered anti-cancer medications prescribed in connection with cancer chemotherapy treatments.
- All non-infused compound Prescriptions that contain at least one FDA approved Prescription ingredient compounded from an FDA approved finished pharmaceutical product and are otherwise covered under the Prescription benefits, **excluding** any bulk powders included in the compound.
- Contraceptive drugs and devices approved by the FDA.
- Specialty Medications.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, when available for administration at a Participating Pharmacy.

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.

Off Label Drugs

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

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; except as covered under this EOC, and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this EOC and require Prior Authorization. The following are examples of Physician supervised drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;

- Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this EOC;
- 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 30-day supply, at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 90-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the benefit schedule).
- 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.
- **You cannot refill a prescription for your 30-day supply until 15 days after it was last filled, and for your 90-day retail/mail-order supply until 69 days after it was last filled, except during a declared state of emergency or disaster.**

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 www.mycigna.com. To obtain Step Therapy Authorization, your Physician must follow the Prescription Drug and Related Supply Authorization and Exception Request Process as described below.

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

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

Expedited Review of a Prior Authorization, Step Therapy or Prescription Drug Exception Request
An expedited review may be requested by your Physician when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a Prescription Drug or Related Supply not on Cigna's Prescription Drug List. The expedited review will be reviewed and completed by Cigna within 24 hours of receipt.

If the request is approved, your Physician will receive confirmation. The Authorization/Exception will be processed in Cigna’s pharmacy claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the Authorization will be granted until you no longer use the Prescription Drug or Related Supply for which the Authorization or Exception was approved. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

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

Appeal of a Prior Authorization, Step Therapy or Prescription Drug Exception Denial
If you, a person acting on your behalf or the prescribing Physician or other prescriber disagree with a coverage decision, you, a person acting on your behalf or the prescribing Physician or other prescriber may appeal that decision in accordance with the provisions of this EOC, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered. Please see the section of this EOC entitled “When You Have a Complaint or an Appeal” which describes the process for the External Independent Review.

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

Coverage of New Drugs

All new Food and Drug Administration (FDA)-approved Prescription Drugs or Related Supplies (or new FDA-approved indications) are designated as Non-Prescription Drug List Prescription Drugs or Related Supplies until the Cigna Business Decision Team makes a placement decision on the new Prescription Drug or

Related Supply (or new indication), which decision shall be based in part on the P&T Committee's clinical review of the drug. The P&T Committee makes a reasonable effort to review all new FDA approved Prescription Drugs or Related Supplies (or new FDA approved indications) within 90 days of its release to the market. The Business Decision Team must make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market, or a clinical justification must be documented if this timeframe is not met.

Reimbursement/Filing a Claim

When a Member purchases Prescription Drugs or Related Supplies through a retail Participating Pharmacy they pay any applicable Copayment, Coinsurance or Deductible shown in the 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

Pediatric Vision Benefits

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

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

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

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

Covered 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

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

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

Exclusions

- Services not provided by a Cigna vision in-network provider.
- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Services or supplies for the treatment of an occupational Injury or Illness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act
- Charges in excess of the usual and customary charge for the service or material
- Charges incurred after the Evidence of Coverage ends or your coverage under the Evidence of Coverage ends, except as stated in the Evidence of Coverage.
- Experimental or non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in “Covered 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 pairs of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in excess of twelve (12) months from the original date of service.
- Services provided out-of-network without Cigna’s prior approval are not covered.

Cigna Vision Providers

To find a Cigna vision provider, 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 number on the back of your ID card.

Pediatric Vision Care Reimbursement/Filing a Claim

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

General Provisions

Workers' Compensation

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

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

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

Recovery of Excess Benefits

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

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.

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 GRIEVANCE OR AN APPEAL

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

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

Start with Member Services.

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

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

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

Appeals Procedure

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

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

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

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

We will acknowledge in writing within 3 working days after We receive your request and schedule a Committee review. The acknowledgement will include the name, address, and telephone number of the Appeal Coordinator and information on how to submit written material. The acknowledgement will also include a description of your appeal rights, including the right to: (a) request and receive all information relevant to the review; (b) attend the Committee meeting; (c) present your case to the Committee and submit supporting materials before and at the Committee meeting; (d) ask questions of any Committee member; and (e) be assisted by a representative of your choice such as a Physician, family member, or attorney. An attorney representing Cigna may also attend. For post-service claims appeals, the

Committee review will be completed within 30 calendar days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, We will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, We will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that You will have an opportunity to respond.

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

Notice of Written Decision
If the decision is not in your favor, Cigna's written decision notice will be provided in writing or electronically, and will include all the following that pertain to the determination.: (1) the professional qualifications and licensure of the person or persons reviewing; (2) a statement of the reviewer's understanding of the reason for the covered person's appeal; (3) the reviewer's decision in clear terms and the medical rationale in sufficient detail for you to respond further to Cigna's position; (4) a reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instruction for requesting the clinical review criteria; (5) notice of the availability of assistance for the Health Insurance Smart NC, including the telephone and address of the program.

Expedited Appeals

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

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

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

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

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

External Review

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

- receive a non-certification decision, or
- receive an appeal decision upholding a non-certification decision, or

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

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

Standard External Review Procedure

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

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

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

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

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

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

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

Expedited External Review Procedure

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

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

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

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

External Review Contact

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

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

In Person:
Health Insurance Smart NC
Albemarle Building
325 N. Salisbury Street
Raleigh, NC 27603
1-855-408-1212 (Toll-free)
https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

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

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.

- **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 10 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 10 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. When We cease to offer policies of this type to all individuals in Your class. In this event, North Carolina 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.
  6. When We cease offering any plans in the individual market in North Carolina, We will notify You of the impending termination of Your coverage at least 180 days prior to Your cancellation.
  7. When the Subscriber no longer works, lives, or resides in the Enrollment Area.
  8. In the event of entry of a final judgment by a court declaring all or part of the Patient Protection and Affordable Care Act (P.L. 111-148) invalid, unconstitutional, or otherwise ineffective, and the state not providing alternative and sufficient means of funding advanced-premium tax credits, this EOC shall be subject to cancellation consistent with applicable federal and state law.

  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.

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

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 immediately upon receipt of due written proof of loss.

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

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 Noncertification, 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 3 business days after receiving 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 90 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Member or their representative responds to the notice. After Cigna receives the missing information, Cigna will notify the Member or their representative of the determination within 3 business days.

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 or Claim 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.

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 90 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date the Member or their representative responds to the notice. After Cigna receives the missing information, Cigna will notify the Member or their representative of the determination within 30 business days.

Notice of Benefit Determination on Appeal

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

Relevant Information

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

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.

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