**Cigna HealthCare of Georgia, Inc.**

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

# Cigna HealthCare of Georgia, Inc. ("Cigna")

# Cigna Connect 150-4

## Health Maintenance Organization (HMO)

## OUTLINE OF COVERAGE

**READ YOUR EVIDENCE OF COVERAGE (EOC) CAREFULLY.** This outline of coverage provides a very brief description of the important features of your EOC. This is not the insurance contract and only the actual EOC provisions will control. The EOC itself sets forth, in detail, the rights and obligations of both You and Cigna HealthCare of Georgia. It is, therefore, important that you **READ YOUR EOC CAREFULLY!**

**A. Coverage is provided by Cigna HealthCare of Georgia, Inc. (referred to herein as "Cigna"),** a health maintenance organization (HMO) which is organized under the laws of the State of GA.

**B.** To **obtain additional information**, including Provider information write to the following address or call the toll-free number:

Cigna HealthCare
Individual Services – Georgia
P.O. Box 30365
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**C.** An HMO EOC requires that the Member use Providers in the Cigna network.

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

A **Non-Participating Provider** (Out-of-Network Provider) means a Provider who does not have a Participating Provider agreement in effect with Cigna at the time services are rendered. Services from Non-Participating Providers are not covered, except for Emergency Medical Condition. You will be responsible for the full cost of non-emergency services from a Non-Participating Provider.

## D. Covered Services and Benefits

See page 4 for complete Benefit Schedule

### Deductibles

**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.

**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.

### Out-of-Pocket Maximum(s)

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

**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.

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

- **For Covered Expenses for Emergency Services performed by a Non-Participating Provider in the Emergency Department of a Hospital or Emergency Services delivered in the Emergency Department of a Non-Participating Hospital or facility,** the amount agreed to by the Non-Participating Provider or Hospital and Cigna or, if no amount is agreed to, **the greatest of** the following, not to exceed the Non-Participating Provider's billed Charges:

- The median amount negotiated with Participating/In-Network Cigna Providers for the same services, or
- The maximum amount Cigna would pay for a non-Emergency Out-of-Network Provider, or
- The amount payable under the Medicare program.

- **For Covered Expenses for non-Emergency Services, <u>the lesser of</u>**:
  - The Provider's normal charge for a similar service or supply; or
  - A percentage of a fee schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

## E. BENEFIT SCHEDULE

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

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

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Medical Benefits** | |
| **Deductible**<br><br>**Individual**<br><br>**Family**<br><br>Deductible applies unless specifically waived. | <br><br>$150<br><br>$300 |
| **Coinsurance** | 5% |
| **Out-of-Pocket Maximum**<br><br>**Individual**<br><br>**Family** | <br><br>$1,250<br><br>$2,500 |
| **Prior Authorization Program**<br><br>**Prior Authorization – Inpatient Services**<br><br>**Prior Authorization – Outpatient Services**<br><br>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." | <br><br>**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.<br><br>**Your Participating Provider must obtain approval** for selected outpatient procedures and services. Failure to do so may result in a penalty or denial of payment for services provided. |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **All Preventive Care Services**<br><br>Please refer to "Comprehensive Benefits: What the EOC Pays For" section of this EOC for additional details | 0%, Deductible waived |
| **Pediatric Vision Care**<br><br>Performed by an Ophthalmologist or Optometrist for a Member, through the end of the month in which the Member turns 19 years of age.<br><br>Please be aware that the pediatric vision network is different from the network of your medical benefits. | |
| **Comprehensive Eye Exam**<br>Limited to one exam per Year | 0%, Deductible waived |
| **Eyeglasses for Children**<br>Limited to one pair per Year<br><br>Pediatric Frames, Single Vision, Lined Bifocal, Lined Trifocal or Standard Progressive and Lenticular Lenses | 0%, Deductible waived |
| **Contact Lenses for Children**<br>Annual limits apply<br><br>Elective and Therapeutic | 0% per pair, Deductible waived |
| **Low Vision Services and Aids**<br>Annual limits apply | 0%, Deductible waived |
| **Physician Services**<br><br>**Office Visit** | |
| **Primary Care Physician** (PCP) | $3 Copayment per visit, Deductible waived |
| **Specialist** (including consultant and second opinion services) | $10 Copayment per visit, Deductible waived |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Other Physician Services** | |
| **Surgery in Physician's office** | 5% |
| **Outpatient Professional Fees** (including surgery, anesthesia, diagnostic procedures, dialysis, radiation therapy) | 5% |
| **Inpatient Surgery, Anesthesia, Radiation Therapy, Chemotherapy** | 5% |
| **In-hospital visits** | 5% |
| **Allergy testing and treatment/injections** | 5% |
| **Virtual Care** | |
| **Dedicated Virtual Care Medical Physician Service** For minor acute medical conditions | $0 Copayment per visit, Deductible waived |
| **Virtual Care Service from Participating Physicians other than Dedicated Virtual Care Physicians** (This benefit excludes any services that are delivered via telephone only.)<br>Note: Any Prescription issued during a virtual visit is subject to all Prescription Drug Benefits, limitations and exclusions. | Same benefit as when service provided in person |
| **Indian Health Program / Tribal Health Program Services***<br>Any Covered Services provided by an Indian Health Program or Tribal Health Program<br>**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**.<br>***See the Definitions section in the EOC for additional information on "Indian Health Program" and the "Tribal Health Program."** | 0%, Deductible waived |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Hospital Services** | |
| **Inpatient Hospital Services** | |
| Facility Charges | 5% |
| Professional Charges | 5% |
| **Emergency Admissions**<br>Facility Charges<br>Professional Charges | Benefits are shown in the Emergency Services schedule |
| **Outpatient Facility Services** Including Diagnostic and Free-Standing Outpatient Surgical and Outpatient Hospital facilities | 5% |
| **Advanced Radiological Imaging** (including MRI's, MRA's, CAT Scans, PET Scans) Facility and interpretation Charges | 5% |
| **All Other Laboratory and Radiology Services** Facility and interpretation Charges | |
| **Physician's Office** | 5% |
| **Free-standing** | |
| Independent Lab | 5% |
| X-ray Facility | 5% |
| **Outpatient Hospital** | |
| Lab | 5% |
| X-ray | 5% |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Rehabilitative Services**<br><br>Maximum of 40 visits per Member, per Calendar Year for all therapies combined<br><br>Maximums for Habilitative Services do not reduce maximums for rehabilitative services.<br><br>Maximum does not apply to services for treatment of Autism Spectrum Disorders. | |
| **Physical Therapy** | 5% |
| **Occupational Therapy** | 5% |
| **Speech Therapy** | 5% |
| **Audiology** | 5% |
| **Cognitive Rehabilitation** | 5% |
| **Spinal Manipulation/Adjustments** | 5% |
| **Cardiac & Pulmonary Rehabilitation** | 5% |
| **Habilitative Services**<br><br>Maximum of 40 visits per Member, per Calendar Year for all therapies combined<br><br>Maximums for rehabilitative services do not reduce maximums for Habilitative Services.<br><br>Maximum does not apply to services for treatment of Autism Spectrum Disorders. | |
| **Physical Therapy** | 5% |
| **Occupational Therapy** | 5% |
| **Speech Therapy** | 5% |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| Treatment of Temporomandibular Joint Dysfunction (TMJ/TMD) | 5% |
| Women's Contraceptive Services, Family Planning and Sterilization | 0%, Deductible waived |
| 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 | 5% |
| **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 |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| Autism Spectrum Disorders<br>For Members under age 21 only<br><br>Diagnosis of Autism Spectrum Disorder<br><br>Office Visit<br><br>Diagnostic testing<br><br>Treatment of Autism Spectrum Disorder<br>(see “Comprehensive Benefits: What the EOC Pays For” section for specific information about what services are covered) | <br><br><br>PCP or Specialist Office Visit benefit applies<br><br>5%<br><br>Copayment or Coinsurance applies for specific benefit provided |
| **Inpatient Services at Other Health Care Facilities**<br><br>Including Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities<br><br>Maximum of 60 days per Member, per Calendar Year for all facilities listed | <br><br>5% |
| **Home Health Care Services**<br><br>Maximum of 120 visits per Member, per Calendar Year.<br>Note: Physical, occupational, speech or respiratory therapy that are part of home health care reduce the maximum for home health care visits, not the maximum for rehabilitative care or pulmonary rehab. | <br><br>5% |
| **Durable Medical Equipment** | 5% |
| **Prosthetics** | 5% |
| **Hospice**<br><br>**Inpatient**<br><br>**Outpatient** | <br><br>5%<br><br>5% |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Dialysis** | |
| **Inpatient** | Inpatient Hospital Services benefit applies |
| **Outpatient** | 5% |
| **Mental Health Disorder** | |
| **Inpatient**<br>(includes Acute and Residential Treatment) | Inpatient Hospital Services benefit applies |
| Outpatient<br>(includes individual, group, intensive outpatient and partial hospitalization) | |
| Office Visit | PCP Office Visit benefit applies |
| All other outpatient services | 5% |
| **Substance Use Disorder** | |
| **Inpatient Rehabilitation**<br>(includes Acute and Residential Treatment) | Inpatient Hospital Services benefit applies |
| **Inpatient Detoxification** | Inpatient Hospital Services benefit applies |
| Outpatient<br>(includes individual, group, intensive outpatient and partial hospitalization) | |
| Office visit | PCP Office Visit benefit applies |
| All other outpatient services | 5% |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| **Organ and Tissue Transplants**<br><br>**Cigna LifeSOURCE Transplant Network® Facility**<br>**Travel Benefit** (Only available through Cigna LifeSOURCE Transplant Network® Facility) Travel benefit Lifetime maximum payment of $10,000<br><br>**Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services**<br><br>**Participating Facility NOT specifically contracted to perform Transplant Services** | 0%<br><br>Inpatient Hospital Services benefit applies<br><br>Not Covered |
| **Ventricular Assist Device Services**<br><br>**Cigna LifeSOURCE Transplant Network® Facility**<br><br>**Non-LifeSOURCE Participating Facility specifically contracted to perform Ventricular Assist Device Services**<br><br>**Participating Facility NOT specifically contracted to perform Ventricular Assist Device Services** | 0%<br><br>Inpatient Hospital Services benefit applies<br><br>Not Covered |
| **Infusion and Injectable Medications and related services or supplies**<br>Administered by a medical professional in an office or outpatient facility | 5% |
| **Nutritional Counseling for Obesity**<br>Limited to 4 visits per year | 5% |
| **Dental Care (other than Pediatric)**<br>Limited to treatment for accidental Injury to natural teeth within 12 months of the accidental Injury. | 5% |

| BENEFIT INFORMATION<br>Note:<br>Covered Services are subject to applicable Deductible unless specifically waived. | PARTICIPATING PROVIDER<br>(Based on the Negotiated Rate for Covered Expenses)<br>YOU PAY |
|---|---|
| Anesthesia **for dental procedures for a dependent child** (up to age 7 or developmentally disabled) | 5% |
| **Medical services for treatment of phenylketonuria (PKU)** | 5% |
| **Specified Diabetic Services and Supplies** | 0%, Deductible waived |

| BENEFIT INFORMATION<br><br>**Emergency Services**<br><br>**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**<br>based on the Negotiated Rate for Covered Expenses | **What You Pay For Non-Participating Providers**<br>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 | 5% | In-Network Cost Share applies |
| Non-Emergency Medical Condition | Not Covered<br>(You pay 100% of Charges) | Not Covered<br>(You pay 100% of Charges) |
| **Urgent Care Center Facility** | | |
| Emergency Medical Condition | $20 Copayment per visit, Deductible waived | In-Network Cost Share applies |
| Non-Emergency Medical Condition | $20 Copayment per visit, Deductible waived | Not Covered<br>(You pay 100% of Charges) |
| **Ambulance Services**<br>**Note:** coverage for Medically Necessary transport to the nearest facility capable of handling the Emergency Medical Condition | | |
| **Emergency Transport** | 5% | 5% |

| BENEFIT INFORMATION<br><br>**Emergency Services**<br><br>**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**<br>based on the Negotiated Rate for Covered Expenses | **What You Pay For Non-Participating Providers**<br>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.) | 5% | 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** | 5% | 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:**<br><br>**You can obtain a 30-day supply of any covered Prescription Drug or Related Supply at any Participating Retail Pharmacy.**<br><br>**For Tiers 1 through 4 You can obtain up to a 90-day supply of any covered Prescription Drug or Related Supply at either a 90 Day Retail Pharmacy or through the Express Scripts Pharmacy, Cigna's home delivery Pharmacy.**<br><br>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. | $3 Copayment, Deductible waived per Prescription or refill<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 90-day supply - at a 90 Day Retail Pharmacy. You pay a Copayment for each 30-day supply | $9 Copayment, Deductible waived per Prescription or refill<br><br>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. | $10 Copayment, Deductible waived per Prescription or refill<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 90-day supply - at a 90 Day Retail Pharmacy. You pay a Copayment for each 30-day supply | $30 Copayment, Deductible waived per Prescription or refill<br><br>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. | $30 Copayment per Prescription or refill<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 90-day supply - at a 90 Day Retail Pharmacy. You pay a Copayment for each 30-day supply | $90 Copayment per Prescription or refill<br><br>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<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 90-day supply - at a 90 Day Retail Pharmacy. | 50% per Prescription or refill<br><br>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<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 30-day supply - at a 90 Day Retail Pharmacy. | 50% per Prescription or refill<br><br>Up to a 30-day maximum supply |
| **Preventive Drugs regardless of Tier**<br><br>Drugs designated by the Patient Protection and Affordable Care Act of 2010 as Preventive, including but not limited to:<br><br>▪ women's contraceptives that are Prescribed by a Physician and Generic, or Brand Name with no Generic alternative available; and<br><br>▪ smoking cessation products, limited to a maximum of 2 90-day treatment regimens | 0%, Deductible waived per Prescription or refill<br><br>30-day supply - at any Participating Pharmacy<br>or<br>Up to a 90-day supply at a 90 Day Retail Pharmacy | 0%, Deductible waived per Prescription or refill<br><br>Up to a 90-day maximum supply |

## F. ROLE OF THE PRIMARY CARE PHYSICIAN

### Choosing a Primary Care Physician

A Primary Care Physician may serve an important role in meeting health care needs by providing or arranging for medical care for each Member. For this reason, when you enroll as a Member, you will be asked to select a Primary Care Physician ("PCP"). Your PCP will provide your regular medical care and assist in coordinating your care. You may select your PCP by calling the customer service phone number on your ID card or by visiting Our website at www.mycigna.com. The Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of Your 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.

#### 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 PCP 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 ~~s~~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 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.

## G. Emergency Services and Benefits

Cigna provides reimbursement for emergency care at the Participating Provider level for treatment of an Emergency Medical Condition.

**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.

### Emergency Services and Urgent Care

#### 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 no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to Us as soon as reasonably possible. Coverage for Emergency Services and urgent care received through Non-Participating Providers shall be limited to Covered Services to which you would have been entitled under this EOC, and you will be reimbursed for only the costs that you incur which you would not have incurred if you received the services from a Participating Provider

## H. Member's Financial Responsibility

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

Premiums are to be paid by You to Us.

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

## I. Exclusions, Limitations, and Reductions

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

### Benefit Exclusions

In addition, the following are specifically excluded Services:

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition.
2. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this EOC.
3. Services **not specifically listed as Covered Services** in this EOC.
4. Services or supplies that are **not Medically Necessary**.
5. Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures or Unproven Procedures**.
6. Services **received before the Effective Date of coverage**.
7. Services **received after coverage under this EOC ends**.
8. Services **for which you have no legal obligation to pay** or for which no charge would be made if you did not have a health plan or insurance coverage.
9. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, even if the Member does not claim those benefits.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (b) the **inadvertent release of nuclear energy** when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) a Member **participating in the military service of any country**; (d) a Member **participating in an insurrection, rebellion, or riot;** (e) services received as a direct result of a Member's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Member being engaged in an illegal occupation;** (f) a Member **being intoxicated,** as defined by applicable state law in the state where the Illness occurred **or under the influence of illegal narcotics or non-prescribed controlled substances** unless administered or prescribed by Physician.

11. Any **services provided by a local, state or federal government agency**, except when payment under this EOC is expressly required by federal or state law.
12. Any **services required by state or federal law to be supplied by a public school system** or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
14. **If the Member is eligible for Medicare** Part A, B, C or D, Cigna will provide claim payment according to this EOC minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this EOC.
16. Professional **services or supplies received or purchased directly or on your behalf by anyone, including a Physician, from** any of the following:
    - Yourself or your employer;
    - A person who lives in the Member's home, or that person's employer;
    - A person who is related to the Member by blood, marriage or adoption, or that person's employer; or.
    - A facility or health care professional that provides remuneration to you, directly or indirectly, or to an organization from which you receive, directly or indirectly, remuneration.
17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this EOC.
18. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care**.
19. **Private duty nursing** except when provided as part of the home health care services or Hospice Services benefit in this EOC.
20. Inpatient room and board **Charges in connection with a Hospital stay primarily for environmental change or physical therapy.**
21. Services received during **an inpatient stay when the stay is primarily related to** behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a Mental Health Disorder.
22. **Complementary and alternative medicine services, including but not limited to**: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; Acupuncture; acupressure; acupuncture point injection therapy; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as

covered under “Rehabilitative Therapy” and “Habilitative Therapy” are not subject to this exclusion.

23. Any services or supplies **provided by or at a place for the aged, a nursing home, or any facility** a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
24. **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
26. Inpatient room and board **Charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
27. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.
28. Services **ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility**, when that Physician or other Provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.
29. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this EOC.
30. **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction. This exclusion does not apply to orthodontic treatment for a congenital anomaly related to or developed as a result of cleft palate, with or without cleft lip.
31. **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
32. **Any services covered under both this medical plan and an accompanying exchange-certified pediatric dental plan**, and reimbursed under the dental plan, will not be reimbursed under this plan.
33. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this EOC, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound. This exclusion does not apply to cochlear implants.
34. **Routine hearing tests** except as provided under Preventive Care.
35. **Genetic screening** 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.

36. **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.
37. **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this EOC under Pediatric Vision.
38. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
39. **Cosmetic surgery, therapy** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
40. **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.
41. **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.
42. **Services and procedures for** redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty, blepharoplasty and; orthognathic surgeries **regardless of clinical indications.**
43. 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.
44. Any treatment, prescription drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
45. Surgical services related to treatment of **fertility and/or Infertility** and any artificial means of conception, including, but not limited to, surgical procedures, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian transfer (GIFT) and associated services
46. Treatment for **Infertility or reduced fertility** that results from a prior sterilization procedure or a normal physiological change such as menopause.
47. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).

48. 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.
49. Blood administration **for the purpose of general improvement in physical condition.**
50. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot orthotic devices.
51. **External and internal power enhancements** or power controls for prosthetic limbs and terminal devices.
52. **Myoelectric prostheses** peripheral nerve stimulators.
53. **Electronic prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
54. **Prefabricated foot Orthoses**.
55. **Cranial banding/cranial orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
56. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
57. **Orthoses primarily used for cosmetic** rather than functional reasons.
58. **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.
59. Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Member has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, except as otherwise stated in this EOC.
60. **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.
61. **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.

62. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna.
63. **Nutritional counseling or food supplements**, except as stated in this EOC.
64. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the Covered Services section of this EOC. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers; treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this EOC.
65. **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".
66. 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."
67. **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 except as otherwise stated in this EOC.
68. **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.
69. Charges for the **services of a standby Physician**.
70. Charges for **animal to human organ transplants**.
71. **Claims received by Cigna after 15 months from the date service was rendered**, except in the event of a legal incapacity.
72. Elective, non-medical emergency **abortions** as defined in § 31-9A-2.
73. Enteral feeding (Unless it is documented as a sole source of nutrition).

**Prescription Drug Exclusions:**

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

- Drugs not approved by the Food and Drug Administration;
- 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;
- 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;
- Infertility related drugs, except those required by the Patient Protection and Affordable Care Act (PPACA);
- Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this EOC;
- Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido and/or sexual desire;
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational or Unproven as described in this EOC; except as specifically stated in the sections of this EOC titled “Clinical Trials,” and any benefit language concerning “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals;
- Implantable contraceptive products inserted by the Physician are covered under the EOC’s medical benefits;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies, except for those pertaining to Diabetic Supplies and Equipment;
- Prescription vitamins other than prenatal vitamins; dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;

- Medications used for travel prophylaxis, except anti-malarial drugs;
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Member while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Any Drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician;
- Drug convenience kits;
- Prescriptions more than one year from the original date of issue;
- Any costs related to the mailing, sending or delivery of Prescription Drugs;
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Member.

**Prescription Drug Limitations**

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

- Up to a 30-day supply, at a Participating Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers 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 30-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 30-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.

### Pediatric Vision Care Exclusions

- Services not provided by a Cigna vision in-network provider.
- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any Injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges in excess of the usual and customary charge for the service or material.
- Charges incurred after the 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.

## J. When You Have a Complaint or an Appeal

### WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.
We want you to be completely satisfied with the care and services you receive. That is why we have established a process for addressing your concerns and solving your problems.

### Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.
If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

**Appeals Procedure**

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal, within 365 days of receipt of a denial notice, If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna HealthCare 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 on your Benefit Identification card, explanation of benefits or claim form. If Cigna fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable law.

**Level-One Appeal**

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

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, 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 man-aged without the requested services.
If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

### Step Therapy Override Appeals

Cigna will grant or deny a step therapy exception or appeal of a step therapy exception within:

- Twenty-four hours in an urgent health care situation; and
- Two business days from the date such request or appeal is submitted in a non-urgent health care situation.

### Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of at least three people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. You may present your situation to the Committee in person or by conference call.
For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, re-lied upon or generated by Cigna in connection with the level-two appeal, Cigna 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, Cigna 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 will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, 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 man-aged without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

You are entitled to a prompt and meaningful hearing for issues related to a denial, in whole or in part, of a health care service, treatment, or claim following exhaustion of all standard appeals requirements. The grievance hearing will be conducted by a panel of not less than 3 per-sons, including a Physician other than the medical director of the plan, and a health care provider competent in the treatment or procedure which has been denied. You will be provided prompt notice in writing of the resolution. Immediate appropriate relief will be granted to You when the outcome is favorable to You. For Adverse Determinations, the notice will include specific findings related to the care, the policies, and procedures relied upon in making the determination, the Physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The request for independent review may be submitted only by an insured, the parent or guardian of an insured who is a minor, or a legal guardian or representative of an insured who is incapacitated. The Independent Re-view Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply: the cost of the service must be $500 or more; you must have exhausted the above appeals procedures and remain dissatisfied; c. the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna; or d. the proposed treatment is excluded as experimental, and you have a terminal condition with a substantial probability of causing death within two years or impairing your ability to regain or maintain maximum function; the standard treatments have been exhausted and the treating Physician certifies that there is no standard treatment available under this certificate more beneficial than the proposed treatment; the treating Physician has certified in writing the treatment is likely to be more beneficial than any available standard treatment; and the treating Physician has certified in writing that scientifically valid studies demonstrate that the proposed treatment is likely to be more beneficial to you than available standard treatment. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must complete the written request form and forward it to the Georgia state planning agency. The planning agency will select an Independent Review Organization to review the issue and the Independent Review Organization will make a determination that is binding upon Cigna.

The Independent Review Organization will render an opinion within 15 working days following receipt of all necessary information. When requested and when a delay would be detrimental to your condition, as determined by the treating health care provider, the review shall be completed within 72 hours of receipt of all necessary information.

The Independent Review Program is a voluntary program arranged by Cigna. If you are not fully satisfied with the decision of Cigna’s level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization who are not employed by Cigna HealthCare or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have no yet been dis-charged from the facility, the review shall be completed within 72 hours.

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: in-formation sufficient to identify the claim; the specific reason or rea-sons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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; a statement describing any voluntary appeal procedures offered by the plan, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

**Relevant Information**

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

**Legal Action**

In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the level-one and level-two appeal processes. If your appeal is expedited, there is no need to complete the level-two process prior to bringing legal action. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services.

**Assistance from the State of Georgia**

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time. The Department of Insurance or the Department of Human Resources may be contacted at the following respective addresses and telephone numbers:

Georgia Department of Insurance
2 Martin Luther King, Jr. Drive Floyd Memorial Bldg,
704 West Tower Atlanta, GA 30334
404-656-2056

Georgia Dept. of Human Resources
Two Peachtree Street, NW Suite 33.250
Atlanta, GA 30303-3167
404-657-5550
Two Peachtree Street, NW Suite 33.250
Atlanta, GA 30303-3167
404-657-5550
Atlanta, GA 30303-3167
404-657-5550

## K. Renewability, Eligibility, and Continuation

1. The Evidence of Coverage (EOC) will renew except for the specific events stated in the EOC. Cigna may change the premiums of the EOC after 60 days' written notice to the Insured. However, Cigna will not refuse to renew or change the premium schedule for the EOC on an individual basis, but only for all Subscribers in the same class and covered under the same EOC as You.
2. The HMO plan is designed for residents of Georgia who are not enrolled under or covered by any other group or individual health coverage. You must notify Cigna of all changes that may affect any Member's eligibility under the EOC.
3. You or Your enrolled Family Members will become ineligible for coverage:
    a. When premiums are not paid according to the due dates and grace periods described in the Premium section of the EOC.
    b. When the Subscriber's spouse is no longer married to the Subscriber due to the Subscriber's death, or due to an entry of a valid decree of divorce.
    c. When the Member no longer meets eligibility requirement listed in the Who is Eligible for Coverage section.
    d. The date the EOC terminates; including when the EOC terminates as a result of the Subscriber's written request to terminate the EOC.
    e. The individual is eligible for Medicare Part A and Part B, or Part B only, or Part D, or is eligible for any Medicare benefit Policy offered by Cigna, any direct or indirect affiliate of Cigna.

4. If a Member’s eligibility under this EOC would terminate due to the Subscriber's death, divorce or other reason for the Member's ineligibility stated in the EOC, except for the Subscriber's failure to pay premium, the Member's insurance will be continued if the Member exercising the continuation right notifies Cigna and pays the appropriate monthly premium within 31 days following the date this EOC would otherwise terminate. Coverage will continue without evidence of insurability, and no pre-existing condition limitation will be imposed, unless unexpired prior to continuation under this EOC.

## L. Premium

1. Premiums are payable monthly. The initial premium amount must be submitted with your original application.
2. The premium rates for this EOC are based on the age, place of residence, and the number and relationship of the Subscriber’s Family Member(s) covered by the EOC. Changes in these factors may result in a change in premium.
    a. The rate provided to You is for the residence shown in your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.
    b. Cigna also has the right to change premiums after 60 days’ notice to you.