Cigna Health and Life Insurance Co.: Open Access Plus

Coverage Period: 07/01/2015 - 06/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | **Plan Type:** OAP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$750** person / **$1,500** family For out-of-network providers **$1,500** person / **$3,000** family Does not apply to in-network preventive care & immunizations, out-of-network preventive care & immunizations through age 12 , prescription drugs	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$3,000** person / **$6,000** family / For out-of-network providers **$6,000** person / **$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% co-insurance	30% co-insurance	----------none----------
	Specialist visit	10% co-insurance	30% co-insurance	----------none----------
	Other practitioner office visit	10% co-insurance for chiropractor	30% co-insurance	Coverage for Chiropractic care is limited to 20 days annual max.
	Preventive care/screening/ immunization	No charge/visit No charge/visit No charge/screening No charge/immunizations No charge/immunizations	No charge/visit Not Covered/visit 30% co-insurance/screening No charge/immunizations Not Covered/immunizations	Coverage birth through age 12 Coverage age 13 and older ----------none---------- Coverage birth through age 12 Coverage age 13 and older
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	30% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$15 co-pay/prescription (retail), $30 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	$35 co-pay/prescription (retail), $70 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Non-preferred brand drugs	$60 co-pay/prescription (retail), $120 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	10% co-insurance	30% co-insurance	50% penalty for no precertification.
If you need immediate medical attention	Emergency room services	10% co-insurance	10% co-insurance	----------none----------
	Emergency medical transportation	10% co-insurance	10% co-insurance	----------none----------
	Urgent care	10% co-insurance	10% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	10% co-insurance	30% co-insurance	50% penalty for no precertification.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Mental/Behavioral health inpatient services	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Substance use disorder inpatient services	10% co-insurance	30% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	10% co-insurance	30% co-insurance	----------none----------
	Delivery and all inpatient services	10% co-insurance	30% co-insurance	50% penalty for no precertification.
If you need help recovering or have other special health needs	Home health care	10% co-insurance	30% co-insurance	50% penalty for no precertification. Coverage is limited to 60 days annual max. Maximums cross-accumulate.
	Rehabilitation services	10% co-insurance	30% co-insurance	50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation services; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	10% co-insurance	30% co-insurance	50% penalty for no precertification. Coverage is limited to 60 days annual max
	Durable medical equipment	10% co-insurance	30% co-insurance	50% penalty for no precertification.
	Hospice services	10% co-insurance	30% co-insurance	50% penalty for no precertification.
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Eye care (Children)	• Habilitation services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult)	• Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care • Hearing aids (Children) Hearing aids for children up to age 18 are covered at the same cost share as any other illness		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Division of Insurance at 1-800-930-3745.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,030
- **Patient pays:** $1,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$750
Co-pays	$80
Co-insurance	$650
Limits or exclusions	$30
Total	**$1,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,430
- **Patient pays:** $1,970

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$750
Co-pays	$920
Co-insurance	$20
Limits or exclusions	$280
Total	**$1,970**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 3961301 **BenefitVersion:** 4
Plan Name: Littleton Public Schools- OAP Coinsurance Plan

HP-POL/HP-APP 9/23/12

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Littleton Public Schools
Open Access Plus Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 90%	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable	110%
Calendar Year Deductible	Individual: $750 Family: $1,500	Individual: $1,500 Family: $3,000

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^)

Plan Highlights	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $6,000 Family: $12,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit • All services including Lab & X-ray	Your plan pays 90% ^	Your plan pays 70% ^
Surgery Performed in Physician's Office	Your plan pays 90% ^	Your plan pays 70% ^
Allergy Treatment/Injections	Your plan pays 90% ^	Your plan pays 70% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 90% ^	Your plan pays 70% ^
Preventive Care		
Preventive Care Birth through age 12 Ages 13 and older	Your plan pays 100% Your plan pays 100%	Your plan pays 100% Not covered
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations Birth through age 12 Ages 13 and older	Your plan pays 100% Your plan pays 100%	Your plan pays 100% Not covered
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 70% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Hospital Facility	Your plan pays 90% ^	Your plan pays 70% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 90% ^	Your plan pays 70% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient		
Outpatient Facility Services	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^	Your plan pays 70% ^
Short-Term Rehabilitation	Your plan pays 90% ^	Your plan pays 70% ^
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 60 days • Cardiac Rehabilitation - 36 days • Chiropractic Care - 20 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • 60 days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 90% ^	Your plan pays 70% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Calendar Year	Your plan pays 90% ^	Your plan pays 70% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 90% ^	Your plan pays 70% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%	Not covered
External Prosthetic Appliances (EPA) • $100 EPA annual deductible per Calendar Year • Unlimited maximum per Calendar Year	Your plan pays 90%	Your plan pays 80%

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Routine Foot Disorders	Not covered	Not covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
Hearing Aid • Maximum of 2 devices per 36 Months, 1 per ear • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Coverage through age 17	Your plan pays 90% ^	Your plan pays 70% ^
Varicose Vein Treatment • Unlimited maximum per Calendar Year	Your plan pays 90% ^	Your plan pays 70% ^

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^		Plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging	Plan pays 90% ^	Plan pays 70% ^	Not Applicable	Not Applicable	Plan pays 90% ^		Plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc... Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit								

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	Plan pays 90% ^		Plan pays 90% ^		Plan pays 90% ^	
Urgent Care	Plan pays 90% ^		Plan pays 90% ^		Not Applicable	
* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.						

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Bereavement Counseling	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Note: Services provided as part of Hospice Care Program				
Note: Services where plan deductible applies are noted with a caret (^)				

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Note: Services where plan deductible applies are noted with a caret (^)								

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Elective and non-elective procedures)	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Family Planning - Men's Services	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.										
Note: Services where plan deductible applies are noted with a caret (^)										

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	Plan pays 100%	Plan pays 90% ^	Not covered	Plan pays 100%	Plan pays 90% ^	Not covered
Note: Services where plan deductible applies are noted with a caret (^)						

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Substance Abuse	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Note: Services where plan deductible applies are noted with a caret (^)						

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.

Mental Health and Substance Abuse Services

Mental Health/Substance Abuse Utilization Review, Case Management and Programs

Cigna Behavioral Advantage - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Self Administered injectable drugs - excludes infertility drugs • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Prescription smoking cessation drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes included	**Retail** - 30 day supply Generic: You pay $15 Preferred Brand: You pay $35 Non-Preferred Brand: You pay $60 **Home delivery** - 90 day supply Generic: You pay $30 Preferred Brand: You pay $70 Non-Preferred Brand: You pay $120	Not covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
  - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
  - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
  - Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.

Prescription Drug List:

- Cigna Value Prescription Drug List

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

High Blood Pressure (ACEI/ARB), Cholesterol Lowering (STATIN), Bladder Problems (OAB), Osteoporosis (Bone), ADD/ADHD (ADHD), Allergy (Nasal Steroids), Depression (SSRI/SNRI), Sleep Disorders (HYPNOTICS), Asthma (ASTHMA), Skin Conditions (TI), Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication
- 0 days grace period
- First Fill Pay and Educate included

Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included

Additional Information	
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester)
Maximum Reimbursable Charge Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (110%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.	
Multiple Surgical Reduction Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions In Network: Coordinated by your physician Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. • 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission. • Benefits are denied for any admission reviewed by Cigna Healthcare and not certified. • Benefits are denied for any additional days not certified by Cigna Healthcare.	
Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing In Network: Coordinated by your physician Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. • 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission. • Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.	
Pre-Existing Condition Limitation (PCL) does not apply.	

Additional Information

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.

Exclusions

- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document.
  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental

Exclusions

retardation.

- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, (except as described under "Covered Expenses") including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, 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.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- 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.
- Dental implants for any condition.
- 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.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone or facsimile consultations.
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.