SUMMARY OF BENEFITS Connecticut General Life Insurance Co.

NG2
Open Access Plus Copay Plan

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	Not Applicable	
Coinsurance	You pay 0% Plan pays 100% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
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 (300%) 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.	N/A	300%
Calendar year plan deductible • The amount you pay for any expenses counts towards both your in-network and out-of-network plan deductibles. (Cross accumulation) • After each family member meets his or her individual plan deductible, the plan will pay his or her claims, less any coinsurance amount. After the family plan deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.	**Employee** None **Employee and family** None	**Employee** $500 **Employee and family** $1,000
Calendar year out-of-pocket maximum • The amount you pay for any services counts towards both your in-network and out-of-network out-of-pocket maximums. (Cross accumulation) • Plan deductibles contribute towards your out-of-pocket maximum. • All medial copays and benefit deductibles contribute	**Employee** $1,000 **Employee and family** $2,000	**Employee** $2,000 **Employee and family** $4,000

Annual deductibles and maximums	In-network	Out-of-network
towards the out-of-pocket maximum. • Prescription copays do not contribute towards the out-of-pocket maximum • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.		

Benefits	In-network	Out-of-network
Physician services		
Office visit	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Physician services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	**Inpatient and outpatient services** You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Surgery (in a physician's office)	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% per visit after the plan deductible is met
Preventive care		
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	No charge	You pay 30% Plan pays 70% per visit after the plan deductible is met
Mammogram, PSA, Pap Smear and Maternity Screening • 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.	No charge, no plan deductible	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. • Private room stays may result in extra charges for the patient.	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
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.	Included	Included
Outpatient services		
Outpatient surgery (facility charges)	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient Professional Services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Physical, occupational, cognitive and speech therapy • 60 days per calendar year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Cardiac rehabilitation • Limited to 36 days per calendar year	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Chiropractic care • Limited to 20 days per calendar year	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Lab and X-ray		
Lab and X-ray Physician's office	No charge after the office visit copay	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient hospital facility • Independent x-ray and/or lab facility	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Lab and X-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit. • Independent x-ray and/or lab facility in conjunction with a emergency room visit	No charge	
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) Physician's office visit	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient hospital facility	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient facility	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Emergency room Urgent care facility	No charge	
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Copay waived if admitted, then inpatient hospital charges would apply • Out-of-network services are covered at the in-network rate. • Copay applies to the out-of-pocket maximum	You pay a $150 copay, then no charge	
Ambulance • Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered.	You pay 0% Plan pays 100%	

Benefits	In-network	Out-of-network
Urgent care services • Out-of-network services are covered at the in-network rate. • Copay waived if admitted, then inpatient hospital charges would apply.	You pay a $50 copay	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 90 days per calendar year	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Home health care • 90 days per calendar year Includes outpatient private duty nursing when approved as medically necessary. 16 hour maximum per day	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Hospice Inpatient services Outpatient services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Other health care services		
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	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Durable medical equipment • Unlimited calendar year maximum	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
External prosthetic appliances (EPA) • Unlimited calendar year maximum	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Acupuncture • Unlimited calendar year maximum	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Massage Therapy • Unlimited calendar year maximum	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
TMJ		
• Office visit	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient Facility	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient Facility	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Physician's Services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Maternity care services Covers maternity for employee and all dependents.		
• Initial Visit to Confirm Pregnancy	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Office Visits in addition to the global maternity fee when performed by an OB or Specialist	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Delivery (Inpatient Hospital, Birthing Center)	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Infertility		
• Office visit for testing, treatment and artificial insemination	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient hospital facility	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient hospital facility	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Physician services **Treatment/Surgery –** includes artificial insemination In-vitro, GIFT, ZIFT, etc. Lifetime Maximum: $15,000 per member	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Family Planning- Men's Services • Office visits	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient hospital facility	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient facility	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Physician services **Note**: Surgical services such as a vasectomy are covered (excluding reversals).	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Family Planning- Women's Services • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices as ordered or prescribed by a physician	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: • Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period.		
Inpatient mental health services • Unlimited days per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum.	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient physician's office mental health services • Unlimited visits per calendar year • This includes group therapy mental health and intensive outpatient mental health	You pay $40 per visit	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient facility mental health • Unlimited visits per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes group therapy mental health and intensive outpatient mental health	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met

Benefits	In-network	Out-of-network
Inpatient substance abuse services • Unlimited days per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient physician's office substance abuse services - • Unlimited visits per calendar year • This includes substance abuse intensive outpatient	You pay $40 per visit	You pay 30% Plan pays 70% after the medical plan deductible is met
Outpatient facility substance abuse • Unlimited visits per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes substance abuse intensive outpatient	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the medical plan deductible is met
Prescription drugs		
CIGNA Pharmacy three-tier copay plan • Dispense as written • Self administered injectable and optional injectable drugs • Includes Oral Contraceptives – with specific products covered at 100% • Lifestyle drugs – limited to sexual dysfunction • Oral fertility drugs included • Smoking cessation drugs **Step Therapy** 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. Some Step 3 (Non Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.	**Retail** (30 day supply) You pay: Generic $10 Preferred Brand $25 Non-Preferred Brand $50 **Home Delivery** (90 day supply) You pay: Generic $25 Preferred Brand $62 Non-Preferred Brand $125	You pay 30% per prescription order or refill

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.
- Some Step 3 (Non Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

Benefits	In-network	Out-of-network

High Blood Pressure (ACEI/ARB)
- Stacked Multidrug Prerequisite Both
- Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Cholesterol Lowering (STATIN)
- Stacked Multidrug Prerequisite Both
- Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Heartburn/Ulcer (PPI)
- Stacked Multidrug Prerequisite Both
- Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Bladder Problems (OAB)
- Stacked Multidrug Prerequisite Both
- Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Osteoporosis (Bone)
- Stacked Multidrug Prerequisite Both
- Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Sleep Disorders (HYPNOTICS)
- Generic or PB First One Step - Step1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Allergy (Nasal Steroids)
- Stacked Multidrug - Prerequisite Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Depression (SSRI/SNRI)
- Stacked Multidrug - Prerequisite Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Skin Conditions (TI)
- Generic First One Step - Step1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non Preferred Brand) medication.
- 60 Days grace period
- First Fill Pay and Educate included

Mental Health (ATYPICAL _PSYCHS)
- Generic or PB First One Step - Step1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to

Benefits	In-network	Out-of-network
using a Step 3 (Non Preferred Brand) medication. • 60 Days grace period • First Fill Pay and Educate included <u>Non-Narcotic Pain relievers (NSAID)</u> • Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication. • 60 Days grace period • First Fill Pay and Educate included <u>ADD/ADHD (ADHD)</u> • Stacked Multidrug Prerequisite Both • Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non Preferred Brand) medication. • 60 Days grace period • First Fill Pay and Educate included <u>Asthma (ASTHMA)</u> • Generic or PB First One Step - Step1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non Preferred Brand) medication. • 60 Days grace period • First Fill Pay and Educate included <u>Narcotic Pain Relievers (NARCOTICS)</u> • Generic First One Step - Step1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non Preferred Brand) medication. • 60 Days grace period • First Fill Pay and Educate included		

Definitions

Calendar Year – The term calendar year and policy year may be used interchangeably. Please see your plan administrator for details on which applies to your plan.
The Term Calendar Year means a period of time from January 1st to December 31.
The term Policy Year means a 12 month period of time beginning with the 1st day of the month your coverage began.
A Policy Year can begin with any month and will renew 12 months from the date it originated.
All applicable benefits, deductibles, Out of pocket maximums as well as all other benefit maximums will be re-instated on the first day of the month of each Policy Year.
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.

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.

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.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

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.

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.

Maximizing your health care dollars

Log on to myCigna.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, Cigna offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Cigna Home Delivery Pharmacy –You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. Cigna's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Obesity surgery and services
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

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.

Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.

Additional Information

Additional benefit information	In-network	Out-of-network
Pre-admission certification – continued stay review (PHS+)	Coordinated by provider/PCP	Employee is responsible for contacting Cigna Healthcare. A 50% penalty is applied to hospital inpatient charges for failure to contact Cigna Healthcare to pre-certify 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.
Outpatient Prior Authorization Required for selected outpatient procedures and diagnostic testing	Coordinated by Provider/PCP	Employee is responsible for contacting Cigna Healthcare. 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare to pre-certify admission. Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.
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.	
Mental health/Substance abuse utilization review, case management and programs	Capitation (CAP) - Inpatient and Outpatient Management • Case Management and Utilization Review for Inpatient Services (In-Network, Out of Network) and Outpatient Services (In-Network only) Provided by Cigna Behavioral Health (CBH). • Includes Lifestyle Management Programs: Stress management & Tobacco Cessation, Healthy Steps to Weight Loss.)	

Additional benefit information	In-network	Out-of-network
MH/SA Service Specific Administration	Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: • *Partial Hospitalization:* The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services. • *Standard for Residential Treatment:* Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management. • *Intensive Outpatient Program (IOP):* Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.	
Annual reinstatement	Not included	
Allergy treatment/injections	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less	You pay 30% Plan pays 70% after the plan deductible is met
Allergy serum (dispensed by the physician in the office)	No charge	You pay 30% Plan pays 70% after the plan deductible is met
Bereavement counseling - inpatient services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Bereavement counseling – outpatient services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met

Additional benefit information	In-network	Out-of-network
Abortion Provides non-elective coverage only		
• Office Visit	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient Facility	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient Surgical Facility	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient Professional Services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient Professional Services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Organ transplant • Inpatient: Covered at 100% at Lifesource center, otherwise same as plan's inpatient hospital facility benefit	$500 copay per admission, then You pay 0% Plan pays 100%	Not covered
• Physician services: Covered at 100% at Lifesource center; otherwise 100% after plan deductible • Travel maximum $10,000 per transplant (only available if using Lifesource facility)	You pay 0% Plan pays 100%	

Additional benefit information	In-network	Out-of-network
Dental care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth.		
• Office visit	**Primary care physician** You pay $20 per visit **Specialist** You pay $40 per visit	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient Facility	$500 copay per admission, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient Surgical Facility	$250 copay per visit, then You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Inpatient Physician's Services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
• Outpatient Physician's Services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Routine foot disorders	Not covered	Not covered

Additional benefit information	In-network	Out-of-network
Included Health and Wellness Programs		
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	
eVisits	Included	
Lifestyle Management Programs - included with Cigna Behavioral Advantage • Weight Management • Tobacco Cessation • Stress Management	Included	

Exclusions

What's Not Covered (*not all-inclusive*):
Your plan provides coverage for most medically necessary services. 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 illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- 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.
- Any services and supplies for or in connection with experimental, investigational or unproven services. 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, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Covered Services and Supplies."
- 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: 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.
- 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. However, 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 6 months of the 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.
- Medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary. Includes, but not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
- Unless otherwise covered as a basic benefit, 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 being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible

Exclusions

under the Agreement.

- Non-medical 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 non-medical ancillary services for learning disabilities, developmental delays or mental 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 "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or “Breast Reconstruction and Breast Prostheses” sections of "Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Covered Services and Supplies”.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies.”
- 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-implantation 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 Healthplan Medical Director’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.

Exclusions

- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.

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.