

SUMMARY OF BENEFITS



Cigna Health and Life Insurance Co.
For – City of League City
Open Access Plus Buy-Up Plan

**This plan contains a higher level of In-Network benefits for a Client-Specific Network (CSN) as shown in the column labeled “CSN”.
 The CSN network is defined by the Client.**

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	UTMB	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Coinsurance	Your plan pays 90%	Your plan pays 80%	Your plan pays 60%
Maximum Reimbursable Charge	Not Applicable	Not Applicable	115th Percentile
Calendar Year Deductible	Individual: \$250 Family: \$500	Individual: \$750 Family: \$1,500	Individual: \$2,000 Family: \$4,000

- Only the amount you pay for UTMB/In-Network covered expenses counts toward your UTMB/In-Network deductible. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network deductible.
- Copays always apply before plan deductible and coinsurance.
- 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**UTMB****In-Network****Out-of-Network****Calendar Year Out-of-Pocket Maximum**

Individual: \$2,000
 Family: \$4,000

Individual: \$2,000
 Family: \$4,000

Individual: \$10,000
 Family: \$20,000

- Only the amount you pay for UTMB/In-Network covered expenses counts toward your UTMB/In-Network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- 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 Use Disorder 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.

Benefit	UTMB	In-Network	Out-of-Network
Physician Services			
Physician Office Visit – Primary Care Physician (PCP) <ul style="list-style-type: none"> All services including Lab & X-ray Dependent children under age 19 - \$0 copay 	\$10 copay, then your plan pays 100%	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Physician Office Visit – Specialist <ul style="list-style-type: none"> All services including Lab & X-ray Dependent children under age 19 - \$0 copay 	\$10 copay, then your plan pays 100%	\$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Surgery Performed in Physician’s Office – PCP	\$10 copay, then your plan pays 100%	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Surgery Performed in Physician's Office – Specialist	\$10 copay, then your plan pays 100%	\$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Allergy Treatment/Injections Performed in Physician's Office PCP	\$10 copay, then your plan pays 100%	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Allergy Treatment/Injections Performed in Specialist Office	\$10 copay, then your plan pays 100%	\$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Allergy Serum - PCP	Your plan pays 100%	Your plan pays 100%	After the plan deductible is met, your plan pays 60%
Allergy Serum - Specialist <ul style="list-style-type: none"> Dispensed by the physician in the office 	Your plan pays 100%	Your plan pays 100%	After the plan deductible is met, your plan pays 60%
Cigna Telehealth Connection services	Not Applicable	\$5 copay, then your plan pays 100%	Not Covered
Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)			
Preventive Care			
Preventive Care <ul style="list-style-type: none"> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. 	Plan pays 100%	Plan pays 100%	After the plan deductible is met, your plan pays 60%
Immunizations <ul style="list-style-type: none"> Out-of-network immunizations are covered at no charge through age 5 	Plan pays 100%	Plan pays 100%	After the plan deductible is met, your plan pays 60%
Mammogram, PAP, PSA Tests <ul style="list-style-type: none"> Coverage includes the associated Preventive Outpatient Professional Services. Associated wellness exam is covered in-network only. Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. 	Plan pays 100%	Plan pays 100%	Plan pays based on place of service

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Inpatient Hospital Facility	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
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	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient			
Outpatient Facility Services Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Short-Term Rehabilitation – PCP	\$10 copay, then your plan pays 100%	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Short-Term Rehabilitation - Specialist	\$10 copay, then your plan pays 100%	\$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Calendar Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 100 days Cardiac Rehabilitation - 36 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) <ul style="list-style-type: none"> 60 days maximum per Calendar Year (The limit is not applicable to mental health and substance use disorder conditions.) 16 hour maximum per day 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility <ul style="list-style-type: none"> 60 days maximum per Calendar Year 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Durable Medical Equipment <ul style="list-style-type: none"> Unlimited maximum per Calendar Year 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%

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Outpatient

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%

Your plan pays 100%

After the plan deductible is met, your plan pays 60%

External Prosthetic Appliances (EPA)

- Unlimited maximum per Calendar Year

After the plan deductible is met, your plan pays 90%

After the plan deductible is met, your plan pays 80%

After the plan deductible is met, your plan pays 60%

Benefit	UTMB	In-Network	Out-of-Network
Other Health Care Facilities/Services			
Routine Foot Disorders	Not Covered	Not Covered	Not Covered
Hearing Aid <ul style="list-style-type: none"> Maximum of 1 device per 36 months Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Medical Specialty Drugs			
Inpatient <ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient Facility Services <ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Physician's Office <ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges. 	Your plan pays 100%	Your plan pays 100%	After the plan deductible is met, your plan pays 60%
Home <ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges. 	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%

Place of Service - You pay 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
Laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80%	Plan pays 60% ^	Covered same as plan's Emergency Room/Urgent Care Services		Plan pays 80%	Plan pays 60% ^

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Radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 80%	Plan pays 60% ^
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services
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							
NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.							

Place of Service - You pay based on where you receive services.

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

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	\$150 per visit (copay waived if admitted) ^, then your plan pays 80%		Plan pays 80% ^		Plan pays 80% ^	
Urgent Care	\$40 per visit (copay waived if admitted), then your plan pays 100%	Plan pays 60%^	Plan pays 100%	Plan pays 60%^	Not applicable	

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

- This includes an Urgent Care Facility copay of \$10.

Place of Service - You pay based on where you receive services.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Bereavement Counseling	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^

Note: Services provided as part of Hospice Care Program

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

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

Place of Service - You pay based on where you receive services.

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	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

Place of Service - You pay based on where you receive services.

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)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
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Includes surgical services, such as vasectomy (excludes reversals).

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

Place of Service - You pay based on where you receive services.

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

Benefit	Physician's Services - Office Visit		Inpatient Hospital Facility		Outpatient Facility Services		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
Family Planning - Women's Services	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^
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.										
TMJ, Surgical and Non-Surgical	Covered same as plan's Physician's Office Services	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										
Unlimited maximum per lifetime										
NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.										

Place of Service - You pay based on where you receive services.

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 80% ^	Plan pays 60% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 60% ^ up to the following transplant maximums: Bone Marrow - \$130,000 Heart - \$150,000 Heart/Lung - \$185,000 Kidney - \$80,000 Kidney/Pancreas - \$80,000 Liver - \$230,000 Lung - \$185,000 Pancreas - \$50,000

Travel Lifetime Maximum - LifeSOURCE Facility: In and Out-of-Network: \$10,000 maximum per Transplant per Lifetime

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary if the Hospital is in Cigna's Lifesource network, else the In-Network daily or admission copay will apply.

Place of Service - You pay based on where you receive services.

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

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 80% ^	Plan pays 60% ^	\$25 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^	\$25 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^

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.

NOTE: Higher levels of In-Network benefits will apply for CSN as shown previously in this summary.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder 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
Cost Share and Supply		
<p>Cigna Pharmacy Cost Share</p> <ul style="list-style-type: none"> • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) 	<p>Retail (per 30-day supply): Generic Preventive: No Charge Generic: You pay \$4 Preferred Brand: You pay \$25 Non-Preferred Brand: You pay \$50 Specialty: You pay 15%</p> <p>Retail (per 90-day supply): Generic Preventive: No Charge Generic: You pay \$8 Preferred Brand: You pay \$50 Non-Preferred Brand: You pay \$100</p> <p>Home Delivery (per 90-day supply): Generic Preventive: No Charge Generic: You pay \$8 Preferred Brand: You pay \$50 Non-Preferred Brand: You pay \$100</p> <p>Home Delivery (per 30-day supply): Specialty: You pay 15%</p>	<p>You pay 40% Your plan pays 60%</p>
<ul style="list-style-type: none"> • Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan. • Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered. • If a generic is available, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug. • Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits. • If you receive a supply of 34 days or less at home delivery, the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply. 		

Drugs Covered

Prescription Drug List:

Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

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.

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 (115%) 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.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

- \$750 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 - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing (not required for Advanced Radiology Imaging (ARI) including MRI, MRA, CAT scan and PET scans)

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.

- \$750 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.

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.

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.

Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

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, riot or insurrection.
- 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. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
 - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
 - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
 - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; 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.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts,

Exclusions

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.

- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, 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.
- 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), anorgasm, 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, 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 and developmental delays except as provided in this plan.
- 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.
- Aids or devices that assist with non-verbal 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.
- 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 this plan.
- 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.

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- 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 non-participating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Massage therapy.
- Gender reassignment surgery.

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.

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