

SUMMARY OF BENEFITS



Cigna Health and Life Insurance Co.
For - City of Lewisville
Cigna Care Network 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.

Cigna Care Designation (CCD) is designed to help promote quality care and to help employees and their families select the Health Care Professional (HCP) that's best for them. Utilizing Cigna claim information, HCPs are assigned the CCD designation when they meet Cigna's criteria for certain quality, and cost-efficiency measures. CCD is available in certain geographic locations.

This **Cigna Care Network (CCN) Plan** provides a higher level of In-Network benefits (coinsurance and/or copayment) when services are received from CCD HCPs in the following designated specialties:

3 Primary Care Physician (PCP) Types:

Family Practice Internal Medicine Pediatrics

18 Specialist Types:

| | | | |
|-------------------------|---------------------|---------------------|--------------|
| Allergy/Immunology | Endocrinology | Neurology | |
| Cardiology | Gastroenterology | Neurosurgery | Pulmonology |
| Cardio-Thoracic Surgery | General Surgery | OB/GYN | Rheumatology |
| Dermatology | Hematology/Oncology | Ophthalmology | Urology |
| Ear/Nose/Throat | Nephrology | Orthopedics/Surgery | |

There are three categories of HCP within this CCD program with CCN benefit tiering:

- **CCN Designated:** includes major specialties within each CCD designated geography that have been assessed against Cigna's criteria and receive a designation of CCN.
- **Non-CCN Designated:** includes major specialties within a CCD designated geography that have been assessed and DO NOT meet the Cigna criteria to be CCN designated, or that are not in a CCD geography.
- **Non-Reviewed Specialists:** HCPs that are not practicing in one of the major specialties (e.g. Podiatry, Infectious Diseases). These HCPs are not evaluated for CCD.

The In-Network benefits described in the companion summary show both CCN and Non-CCN copayment and coinsurance levels as applicable.

- Note that the CCN levels apply to professional charges and do not apply to facility charges.

- CCN level:**
- **CCN Designated** HCPs performing in one of the above specialties.
- Non-CCN level:**
- **Non-CCN Designated** HCPs performing any service.
 - **Non-Reviewed Specialist** HCPs performing in one of the 18 Specialist Types above.

CCN Tiering applies to Office visits and Inpatient and Outpatient Professional (Surgical) charges, except for Radiologists, Pathologists and Anesthesiologists.

| Plan Highlights | In-Network | Out-of-Network |
|---|--|--|
| Lifetime Maximum | Unlimited | Unlimited |
| Coinsurance | <p><u>Plan Coinsurance</u> Your plan pays 80%</p> <p><u>CCN PCP and CCN Specialist</u> Your plan pays 90%</p> <p><u>Non-CCN PCP and Non-CCN Specialist</u> Your plan pays 80%</p> | Your plan pays 50% |
| Maximum Reimbursable Charge | Not Applicable | 110% |
| <p>Contract Year Deductible</p> <ul style="list-style-type: none"> • 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. <p>Note: Services where plan deductible applies are noted with a caret (^)</p> | <p>Individual: \$5,000 Family: \$10,000</p> | <p>Individual: \$10,000 Family: \$20,000</p> |
| <p>Contract Year Out-of-Pocket Maximum</p> <ul style="list-style-type: none"> • 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 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. • Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket. | <p>Individual: \$6,350 Family: \$12,700</p> | <p>Individual: \$20,000 Family: \$40,000</p> |

| Benefit | In-Network | Out-of-Network |
|---|--|----------------------|
| Note: Services where plan deductible applies are noted with a caret (^) | | |
| Physician Services | | |
| Physician Office Visit <ul style="list-style-type: none"> All services including Lab & X-ray | <u>CCN Primary Care Physician</u> Your plan pays 90% ^ <u>Non-CCN Primary Care Physician</u> Your plan pays 80% ^ <u>CCN Specialist</u> Your plan pays 90% ^ <u>Non-CCN Specialist</u> Your plan pays 80% ^ Your plan pays 100% coinsurance after \$100 copay for Airrosti Rehab Centers | Your plan pays 50% ^ |
| Surgery Performed in Physician's Office (** CCN Benefit level may apply) | Your plan pays 80% ** ^ | Your plan pays 50% ^ |
| Allergy Treatment/Injections (** CCN Benefit level may apply) | Your plan pays 80% ** ^ | Your plan pays 50% ^ |
| Allergy Serum Dispensed by the physician in the office (** CCN Benefit level may apply) | Your plan pays 80% ** ^ | Your plan pays 50% ^ |
| 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. Includes preventive and diagnostic colonoscopies and related charges. | Your plan pays 100% | Your plan pays 50% ^ |
| Immunizations | Your plan pays 100% | Your plan pays 50% ^ |
| Mammogram, PAP, and PSA Tests <ul style="list-style-type: none"> 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. | Your plan pays 100% | Your plan pays 50% ^ |
| Inpatient | | |

| Benefit | In-Network | Out-of-Network |
|--|--|----------------------|
| Note: Services where plan deductible applies are noted with a caret (^) | | |
| Inpatient Hospital Facility | Your plan pays 80% ^ | Your plan pays 50% ^ |
| 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 (** CCN Benefit level may apply) | <u>Primary Care Physician</u> Your plan pays 80% ^ <u>Specialist**</u> Your plan pays 80% ^ | Your plan pays 50% ^ |
| Inpatient Professional Services <ul style="list-style-type: none">For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists (** CCN Benefit level may apply for Surgeons only) | <u>Primary Care Physician</u> Your plan pays 80% ^ <u>Specialist**</u> Your plan pays 80% ^ | Your plan pays 50% ^ |
| Outpatient | | |
| Outpatient Facility Services | Your plan pays 80% ^ | Your plan pays 50% ^ |
| Outpatient Professional Services <ul style="list-style-type: none">For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists (** CCN Benefit level may apply for Surgeons only) | <u>Primary Care Physician</u> Your plan pays 80% ^ <u>Specialist**</u> Your plan pays 80% ^ | Your plan pays 50% ^ |
| Short-Term Rehabilitation Contract Year Maximums: <ul style="list-style-type: none">Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited daysChiropractic Care – 25 days | Your plan pays 80% ^ | Your plan pays 50% ^ |
| 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">120 days maximum per Contract Year16 hour maximum per day | Your plan pays 80% ^ | Your plan pays 50% ^ |
| Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility <ul style="list-style-type: none">90 days maximum per Contract Year | Your plan pays 80% ^ | Your plan pays 50% ^ |
| Durable Medical Equipment <ul style="list-style-type: none">Unlimited maximum per Contract Year | Your plan pays 80% ^ | Your plan pays 50% ^ |

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| Benefit | In-Network | Out-of-Network |
|--|----------------------|----------------------|
| Note: Services where plan deductible applies are noted with a caret (^) | | |
| Breast Feeding Equipment and Supplies <ul style="list-style-type: none"> 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 50% ^ |
| External Prosthetic Appliances (EPA) <ul style="list-style-type: none"> Unlimited maximum per Contract Year | Your plan pays 80% ^ | Your plan pays 50% ^ |
| 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 Exams <ul style="list-style-type: none"> Unlimited maximum per Contract Year | Your plan pays 80% ^ | Your plan pays 50% ^ |
| Hearing Aid <ul style="list-style-type: none"> Unlimited maximum devices per Lifetime Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level | Your plan pays 80% ^ | Your plan pays 80% ^ |
| Wigs <ul style="list-style-type: none"> \$300 maximum per Contract Year | Your plan pays 80% ^ | Your plan pays 80% ^ |

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 (** CCN Benefit level may apply) | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | | Plan pays 80% ** ^ | Plan pays 50% ^ |
| Advanced Radiology Imaging (** CCN Benefit level may apply) | Plan pays 80% ** ^ | Plan pays 50% ^ | Not Applicable | Not Applicable | Plan pays 80% ** ^ | | Plan pays 80% ** ^ | Plan pays 50% ^ |

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 (** CCN Benefit level may apply) | Plan pays 80% ** ^ | | Plan pays 80% ** ^ | | Plan pays 80% ^ | |
| Urgent Care (** CCN Benefit level may apply) | Plan pays 80% ** ^ | | Plan pays 80% ** ^ | | 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 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |
| Bereavement Counseling | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |

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 (** CCN Benefit level may apply) | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ | 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 Professional Services | | 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 |
| Note: Services where plan deductible applies are noted with a caret (^) | | | | | | | | | | |
| Abortion (Elective and non-elective procedures) (** CCN Benefit level may apply for Surgeons only) | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ |
| Family Planning - Men's Services (** CCN Benefit level may apply for Surgeons only) | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ |
| Includes surgical services, such as vasectomy (excludes reversals) | | | | | | | | | | |
| Family Planning - Women's Services | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Plan pays 50% ^ |
| 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. | | | | | | | | | | |

| Benefit | Physician's Office | | Ambulatory | | 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 |
| Note: Services where plan deductible applies are noted with a caret (^) | | | | | | | | | | |
| TMJ, Surgical and Non-Surgical (** CCN Benefit level may apply for Surgeons only) | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ | Plan pays 80% ** ^ | Plan pays 50% ^ |
| Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. | | | | | | | | | | |
| Unlimited maximum per lifetime | | | | | | | | | | |
| Bariatric Surgery (** CCN Benefit level may apply for Surgeons only) | Plan pays 80% ** ^ | Not Covered | Plan pays 80% ^ | Not Covered | Plan pays 80% ^ | Not Covered | Plan pays 80% ** ^ | Not Covered | Plan pays 80% ** ^ | Not Covered |
| Surgeon Charges Lifetime Maximum: Unlimited | | | | | | | | | | |
| Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: | | | | | | | | | | |
| <ul style="list-style-type: none"> • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision | | | | | | | | | | |

| 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 (** CCN Benefit level may apply for Surgeons only) | Plan pays 100% | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 100% | Plan pays 80% ** ^ | Plan pays 50% ^ |

- Travel Lifetime Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant per Lifetime

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 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |
| Substance Use Disorder | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |

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

Note: Detox is covered under medical

- Unlimited maximum per Contract 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 Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - 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 |
|---|--|--|
| <p>Cigna Pharmacy three-tier coinsurance plan</p> <ul style="list-style-type: none"> Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. When patient requests brand drug, patient pays the generic coinsurance plus the cost difference between the brand and generic drugs up to the cost of the brand drug. Your pharmacy benefits have a combined annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met. Self Administered injectable and optional injectable drugs - excludes infertility drugs Oral contraceptives included Includes oral contraceptives - with specific products covered 100% Lifestyle drugs included - limited to sexual dysfunction Prescription smoking cessation drugs included Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included Specialty medications are limited to a 30-day supply | <p>Retail - 30 day supply Generic: You pay 10% ^ Preferred Brand: You pay 30% ^ subject to a maximum of \$150 Non-Preferred Brand: You pay 40% ^ subject to a maximum of \$150</p> <p>Home delivery - 90 day supply Generic: You pay 10% ^ Preferred Brand: You pay 25% ^ subject to a maximum of \$300 Non-Preferred Brand: You pay 40% ^ subject to a maximum of \$300</p> | <p>Retail You pay 50% ^ Your plan pays 50%</p> <p>Home Delivery Not Covered</p> |

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 - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

Prescription Drug List:

- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

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

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Pharmacy Program Information

myCigna.com.

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

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 - Step 1 (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.

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Pharmacy Program Information

- 60 Days grace period
- First Fill Pay and Educate included

Skin Conditions (TI)

- 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.
- 60 Days grace period
- First Fill Pay and Educate included

Mental Health (ATYPICAL PSYCHS)

- Generic or PB First One Step - Step 1 (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

Non-Narcotic Pain relievers (NSAID)

- 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

ADD/ADHD (ADHD)

- 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

Asthma (ASTHMA)

- Generic or PB First One Step - Step 1 (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

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.

Additional Information

Maximum Reimbursable Charge

Out-of-Network services are subject to a Contract 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.

- \$250 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.

- \$250 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.

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):

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Exclusions

- 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 Service (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 Service, 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.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; 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. 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.

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- 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 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 intellectual disabilities.
- 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, and dentures.
- 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.

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Exclusions

- 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, e-mail, and Internet consultations, and telemedicine.
- 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.

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