

# SUMMARY OF BENEFITS



**Connecticut General Life Insurance Co.**  
**For - City of Lewisville**  
**Cigna Care Network Choice Fund Open Access Plus HSA 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](http://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](http://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:

<u>3 Primary Care Physician (PCP) Types:</u>			
Family Practice	Internal Medicine	Pediatrics	
<u>18 Specialist Types:</u>			
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.

**Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.**

**Employer Contribution**

Employee - \$500  
Employee + 1 - \$1,000  
Family - \$1,000

**Plan Highlights****In-Network****Out-of-Network****Lifetime Maximum**

Unlimited

Unlimited

**Coinsurance****Plan Coinsurance**

Your plan pays 80%

**CCN PCP and CCN Specialist**

Your plan pays 90%

**Non-CCN PCP and Non-CCN Specialist**

Your plan pays 80%

Your plan pays 50%

**Maximum Reimbursable Charge**

Not Applicable

110%

**Contract Year Deductible**Individual: \$3,000  
Family: \$6,000Individual: \$7,500  
Family: \$15,000

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy deductible.
- Preventive generic prescription drugs are not subject to the plan deductible.

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

Plan Highlights	In-Network	Out-of-Network
<b>Contract Year Out-of-Pocket Maximum</b>	Individual: \$5,950 Family: \$11,900	Individual: \$17,000 Family: \$34,000
<ul style="list-style-type: none"> <li>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.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li> <li>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.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> <li>Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.</li> </ul>		

Benefit	In-Network	Out-of-Network
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**Note: Services where plan deductible applies are noted with a caret (^)**

### Physician Services

<b>Physician Office Visit</b> <ul style="list-style-type: none"> <li>All services including Lab &amp; X-ray</li> </ul>	<u><b>CCN Primary Care Physician</b></u> Your plan pays 90% ^	Your plan pays 50% ^
	<u><b>Non-CCN Primary Care Physician</b></u> Your plan pays 80% ^	
	<u><b>CCN Specialist</b></u> Your plan pays 90% ^	
	<u><b>Non-CCN Specialist</b></u> Your plan pays 80% ^	
<b>Surgery Performed in Physician's Office</b> (** CCN Benefit level may apply)	Your plan pays 80% ** ^	Your plan pays 50% ^
<b>Allergy Treatment/Injections</b> (** CCN Benefit level may apply)	Your plan pays 80% ** ^	Your plan pays 50% ^
<b>Allergy Serum</b> Dispensed by the physician in the office (** CCN Benefit level may apply)	Your plan pays 80% ** ^	Your plan pays 50% ^

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>		
<b>Preventive Care</b>		
<b>Preventive Care</b>	Your plan pays 100%	Your plan pays 50% ^
<ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> </ul>		
<b>Immunizations</b>	Your plan pays 100%	Your plan pays 50% ^
<b>Mammogram, PAP, and PSA Tests</b>	Your plan pays 100%	Your plan pays 50% ^
<ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>		
<b>Inpatient</b>		
<b>Inpatient Hospital Facility</b>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	<u>Primary Care Physician</u> Your plan pays 80% ^	Your plan pays 50% ^
<b>(** CCN Benefit level may apply)</b>	<u>Specialist**</u> Your plan pays 80% ^	
<b>Inpatient Professional Services</b>	<u>Primary Care Physician</u> Your plan pays 80% ^	Your plan pays 50% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul> <b>(** CCN Benefit level may apply for Surgeons only)</b>	<u>Specialist**</u> Your plan pays 80% ^	
<b>Outpatient</b>		
<b>Outpatient Facility Services</b>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Outpatient Professional Services</b>	<u>Primary Care Physician</u> Your plan pays 80% ^	Your plan pays 50% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul> <b>(** CCN Benefit level may apply for Surgeons only)</b>	<u>Specialist**</u> Your plan pays 80% ^	
<b>Short-Term Rehabilitation</b>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Contract Year Maximums:</b> <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days</li> <li>Chiropractic Care – 25 days</li> </ul>		
<b>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</b>		

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>120 days maximum per Contract Year</li> <li>16 hour maximum per day</li> </ul>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>90 days maximum per Contract Year</li> </ul>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Contract Year</li> </ul>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>Includes related supplies</li> </ul>	Your plan pays 100%	Your plan pays 50% ^
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Contract Year</li> </ul>	Your plan pays 80% ^	Your plan pays 50% ^
<b>Routine Foot Disorders</b>	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
<b>Hearing Aids</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Lifetime</li> </ul>	Your plan pays 80% ^	Your plan pays 80% ^
<b>Wigs</b> <ul style="list-style-type: none"> <li>\$300 maximum per Contract Year</li> </ul>	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
<b>Lab and X-ray</b> <b>(** CCN Benefit level may apply)</b>	Plan pays 80% ** ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ** ^		Plan pays 80% ** ^	Plan pays 50% ^

## 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
<b>Advanced Radiology Imaging</b> <b>(** CCN Benefit level may apply)</b>	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
<b>Emergency Care</b> <b>(** CCN Benefit level may apply)</b>	Plan pays 80% ** ^		Plan pays 80% ** ^		Plan pays 80% ^	
<b>Urgent Care</b> <b>(** CCN Benefit level may apply)</b>	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
<b>Hospice</b>	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^
<b>Bereavement Counseling</b>	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
<b>Maternity</b> <b>(** CCN Benefit level may apply)</b>	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 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

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

<b>Abortion</b> (Elective and non-elective procedures)  <b>(** CCN Benefit level may apply for Surgeons only)</b>	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% ^
<b>Family Planning - Men's Services</b>  <b>(** CCN Benefit level may apply for Surgeons only)</b>	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)

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
Note: Services where plan deductible applies are noted with a caret (^)										
<b>Family Planning - Women's Services</b>	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.										
<b>Infertility</b> <b>Note:</b> 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.										
<b>TMJ, Surgical and Non-Surgical</b>	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% ^
<b>(** CCN Benefit level may apply for Surgeons only)</b>										
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										
Unlimited maximum per lifetime										
<b>Bariatric Surgery</b>	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
<b>(** CCN Benefit level may apply for Surgeons only)</b>										
<b>Surgeon Charges Lifetime Maximum:</b> 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"> <li>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.</li> <li>weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision</li> </ul>										

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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><b>Cigna Pharmacy three-tier coinsurance plan</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>Self Administered injectable and optional injectable drugs - excludes infertility drugs</li> <li>Oral contraceptives included</li> <li>Includes oral contraceptives - with specific products covered 100%</li> <li>Lifestyle drugs included - limited to sexual dysfunction</li> <li>Prescription smoking cessation drugs included</li> <li>Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges included</li> <li>Specialty medications are limited to a 30-day supply</li> </ul>	<p><b>Retail</b> - 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><b>Home delivery</b> - 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><b>Retail</b>  You pay 50%^  Your plan pays 50%</p> <p><b>Home Delivery</b>  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 myCigna.com.
- Some Step 3 (Non-Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

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## Pharmacy Program Information

### 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.
- 60 Days grace period

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## Pharmacy Program Information

- 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

### Health Advisor - A

Support for healthy and at-risk individuals to help them stay healthy

- Health and Wellness Coaching
- Gaps in Care coaching for select conditions
- Preference Sensitive Care/Treatment Decision Support Coaching

Included

### 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):

- 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 do not include routine patient care costs related to qualified clinical trials as described in your plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: 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.
- Treatment of TMJ disorder.
- 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

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## Exclusions

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, including clinically severe (morbid) obesity, including: 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; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
- 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."
- Infertility services, 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 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 or supplies 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 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, autism 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 and dentures.
- 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 post cataract surgery).
- Routine refraction, 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, 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.

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## Exclusions

- 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.
- 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.

### **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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