

SUMMARY OF BENEFITS



Cigna Health and Life Insurance Co.
For - City of Lewisville
LocalPlus Plan

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

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 80%	Your plan pays 50%
Maximum Reimbursable Charge	Not Applicable	110%
Contract Year Deductible	Individual: \$5,000 Family: \$10,000	Individual: \$10,000 Family: \$20,000
<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>		
Contract Year Out-of-Pocket Maximum	Individual: \$6,350 Family: \$12,700	Individual: \$20,000 Family: \$40,000
<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. 		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
Physician Services		
Physician Office Visit • All services including Lab & X-ray	Your plan pays 80% ^ Your plan pays 100% coinsurance after \$25 copay of Airrosti Rehab Centers	Your plan pays 50% ^
Surgery Performed in Physician's Office	Your plan pays 80% ^	Your plan pays 50% ^
Allergy Treatment/Injections	Your plan pays 80% ^	Your plan pays 50% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 80% ^	Your plan pays 50% ^
Cigna Telehealth Connection services • 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)	Your plan pays 80% ^	Not Covered
Preventive Care		
Preventive Care • 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 Birth through age 5	Your plan pays 100%	Your plan pays 100%
Ages 6 and older	Your plan pays 100%	Your plan pays 50% ^
Mammogram, PAP, and PSA Tests • 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		
Inpatient Hospital Facility 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	Your plan pays 80% ^	Your plan pays 50% ^
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 80% ^	Your plan pays 50% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 80% ^	Your plan pays 50% ^
Outpatient		
Outpatient Facility Services	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 (^).		
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	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 days Chiropractic 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 Year 16 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% ^
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 Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	Not Covered	Not Covered
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. 	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	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^		Plan pays 80% ^	Plan pays 50% ^
Advanced Radiology Imaging	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	Plan pays 80% ^		Plan pays 80% ^		Plan pays 80% ^	
Urgent Care	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	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
Abortion (Elective and non-elective procedures)	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	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.									
TMJ, Surgical and Non-Surgical	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	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 										
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 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, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

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

Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs

Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		

Pharmacy	In-Network	Out-of-Network
<p>Cigna Pharmacy Cost Share</p> <ul style="list-style-type: none"> • Retail – up to 90-day supply • Home Delivery – up to 90-day supply 	<p>Retail (per 30-day supply): Generic: You pay 10% Preferred Brand: You pay 30% up to a maximum of \$150 Non-Preferred Brand: You pay 40% up to a maximum of \$150</p> <p>Retail (per 90-day supply): Generic: You pay 10% Preferred Brand: You pay 25% up to a maximum of \$300 Non-Preferred Brand: You pay 40% up to a maximum of \$300</p> <p>Home Delivery (per 90-day supply): Generic: You pay 10% Preferred Brand: You pay 25% up to a maximum of \$300 Non-Preferred Brand: You pay 40% up to a maximum of \$300</p>	<p>Retail: You pay 50% Your plan pays 50%</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. • When patient requests brand drug, patient pays the generic 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 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. • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply. • Preventive generic prescription drugs are not subject to the plan deductible. 		

Drugs Covered

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.

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.
- Lifestyle drugs are covered - limited to sexual dysfunction.
- Generic Non-Sedating Anti-histamines are covered.
- Prescription smoking cessation drugs are covered.
- Generic Ulcer Drugs (Proton Pump Inhibitors/PPI) are covered.

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - 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.
- Prior authorization is required on specialty medications and quantity limits may apply.
- 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.

Pharmacy Cost Management Program

Step Therapy: Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.

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Pharmacy Program Information

- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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Pharmacy Program Information

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

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 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.

Medicare Coordination

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 as permitted by the Social Security Act of 1965** 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.

This plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Additional Information

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 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

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Exclusions

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:
 - o 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;
 - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - o 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
 - o 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: 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.
- 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

Exclusions

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.
- 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 this plan.
- 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 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, dentures.
- 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.
- 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 this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-participating provider.

10/1/2017

ASO

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Exclusions

- 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.
- Services for gender reassignment surgery (male-to-female or female to male) including, when applicable, hormone therapy, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy and salpingo-oophorectomy, as well as initial mastectomy or breast reduction.

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.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

EHB State: TX

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LỜI Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).