## SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.  
For - Oberlin College  
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, 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.

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

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Your plan pays 80%</td>
<td>Your plan pays 60%</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>110%</td>
</tr>
</tbody>
</table>

### Calendar Year Deductible

- 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.
- Plan deductible always applies before any copay or coinsurance.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.

**Note:** Services where plan deductible applies are noted with a caret (^).
### Plan Highlights

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual: $4,000</td>
<td>Individual: $8,000</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner or</td>
<td>Employee + Spouse/Domestic Partner or</td>
</tr>
<tr>
<td>Employee + Child(ren): $6,000</td>
<td>Employee + Spouse/Domestic Partner or</td>
</tr>
<tr>
<td>Individual in a Family: $6,850</td>
<td>Employee + Child(ren): $12,000</td>
</tr>
<tr>
<td>Family: $8,000</td>
<td>Individual in a Family: $16,000</td>
</tr>
<tr>
<td>Family: $8,000</td>
<td>Family: $16,000</td>
</tr>
</tbody>
</table>

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for your 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.
- 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 has been met, the plan will pay 100% of each eligible family member's covered expense 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.

### Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit – Primary Care Physician (PCP)</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>All services including Lab &amp; X-ray</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Physician Office Visit – Specialist</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>All services including Lab &amp; X-ray</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Performed in Physician's Office - PCP</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Surgery Performed in Physician's Office – Specialist</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Allergy Treatment/Injections Performed in Physician's Office PCP</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Allergy Treatment/Injections Performed in Specialist Office</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Allergy Serum - PCP</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Allergy Serum - Specialist</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>• Dispensed by the physician in the office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Cigna Telehealth Connection services</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Plan pays 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mammogram, PAP, and PSA Tests</td>
<td>Plan pays 100%</td>
<td>Plan pays based on place of service.</td>
</tr>
<tr>
<td>• Coverage includes the associated Preventive Outpatient Professional Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Associated wellness exam is covered in-network only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Cancer Detection Colon/Rectal</td>
<td>Plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>• Preventive is covered at 100%. Deductible is waived and no maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Deductible applies to diagnostic services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Physician’s Visit/Consultation</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>After the plan deductible is met, your plan pays 80%</td>
<td>After the plan deductible is met, your plan pays 60%</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
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<td></td>
</tr>
</tbody>
</table>

1/1/2018
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### Benefit | In-Network | Out-of-Network
--- | --- | ---
**Short-Term Rehabilitation - PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60%
**Short-Term Rehabilitation – Specialist** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60%

**Calendar Year Maximums:**
- Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Care and Cardiac Rehabilitation – Unlimited days
- Speech Therapy is covered for functional speech disorder without an underlying medical condition includes coverage for autism spectrum disorders and developmental delays.

**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)
- Unlimited days maximum per Calendar Year
- 16 hour maximum per day

**Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility**
- Unlimited days maximum per Calendar Year

**Durable Medical Equipment**
- Unlimited maximum per Calendar Year

**Breast Feeding Equipment and Supplies**
- Limited to the rental of one breast pump per birth as ordered or prescribed by a physician
- Includes related supplies

**External Prosthetic Appliances (EPA)**
- Unlimited maximum per Calendar Year

**Oral Surgery**
- Excision of tumors and cyst of jaws, cheeks, lips, tongue, roof and floor of mouth
- Excision of benign bony growths of the jaw and hard palate
- External incision and drainage of cellulitis
- Incision of sensory sinuses, salivary glands or ducts
- Removal of impacted teeth

**Routine Foot Disorders**
- $700 maximum per Calendar Year for Physician’s Services

Your plan pays 100%

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

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

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

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

After the plan deductible is met, your plan pays 100%

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

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

Covered same as plan's Physician’s Office Services

Covered same as plan's Physician’s Office Services
### Benefit

#### In-Network

**Bone Density Testing**
- Bone Density testing is covered when Medically Necessary and once every five years as a preventive test for ages 35 and older in-network and out-of-network.
  - Your plan pays 80%
  - After the plan deductible is met, your plan pays 60%

#### Out-of-Network

**Medical Specialty Drugs**
- This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.
  - After the plan deductible is met, your plan pays 80%
  - After the plan deductible is met, your plan pays 60%

**Outpatient Facility Services**
- This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.
  - After the plan deductible is met, your plan pays 80%
  - After the plan deductible is met, your plan pays 60%

**Physician's Office**
- This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician’s Office. This benefit does not cover the related Office Visit or Professional charges.
  - After the plan deductible is met, your plan pays 80%
  - After the plan deductible is met, your plan pays 60%

**Home**
- This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient’s home. This benefit does not cover the related Professional charges.
  - After the plan deductible is met, your plan pays 80%
  - After the plan deductible is met, your plan pays 60%

#### Place of Service - your plan pays based on where you receive services

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Plan pays 80%</td>
<td>Plan pays 60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
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<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Advanced Radiology Imaging</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
<td>Covered same as plan's Outpatient Facility Services</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
<td>Covered same as plan's Outpatient Facility Services</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
<td>Covered same as plan's Outpatient Facility Services</td>
</tr>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Not Applicable</td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
<td>Covered same as plan's Outpatient Facility Services</td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Emergency Room / Urgent Care Facility</th>
<th>Outpatient Professional Services</th>
<th>*Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 80% ^</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 80% ^</td>
<td>Not Applicable *</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital and Other Health Care Facilities</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 60% ^</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 60% ^</td>
</tr>
</tbody>
</table>

*Note: Services provided as part of Hospice Care Program.*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Initial Visit to Confirm Pregnancy</th>
<th>Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)</th>
<th>Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)</th>
<th>Delivery - Facility (Inpatient Hospital, Birthing Center)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Maternity</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Plan pays 80% ^</td>
<td>Covered same as plan's Physician's Office Services</td>
</tr>
<tr>
<td></td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Plan pays 60% ^</td>
<td>Covered same as plan's Physician's Office Services</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% ^</td>
<td>Plan pays 60% ^</td>
<td>Covered same as plan's Physician's Office Services</td>
<td>Covered same as plan's Inpatient Hospital benefit</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network</td>
<td>Out-of-Network</td>
<td>Covered same as plan's Inpatient Hospital benefit</td>
<td>Covered same as plan's Inpatient Hospital benefit</td>
</tr>
</tbody>
</table>

*Note: Services where plan deductible applies are noted with a caret (^).*
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Abortion (Elective and non-elective</td>
<td>Covered same as plan's</td>
<td>Covered same as</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td>procedures)</td>
<td>plan's Physician's</td>
<td>plan's Physician's</td>
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</tr>
<tr>
<td></td>
<td>Office Services</td>
<td>Office Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning - Men's Services</td>
<td>Covered same as plan's</td>
<td>Covered same as</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
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<tr>
<td></td>
<td>plan's Physician's</td>
<td>plan's Physician's</td>
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<tr>
<td></td>
<td>Office Services</td>
<td>Office Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning - Women's Services</td>
<td>Plan pays 100%</td>
<td>Covered same as</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
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<td></td>
<td>plan's Physician's</td>
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<tr>
<td></td>
<td></td>
<td>Office Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>Covered same as plan's</td>
<td>Not Covered</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
<td>Plan pays 80%</td>
</tr>
<tr>
<td></td>
<td>plan's Physician's</td>
<td></td>
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<tr>
<td></td>
<td>Office Services</td>
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<td>TMJ, Surgical and Non-Surgical</td>
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<td>Plan pays 80%</td>
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<td>Office Services</td>
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<td>Includes surgical services, such as</td>
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<td>Abortion (Elective and non-elective</td>
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<td>Family Planning - Men's Services</td>
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<td>Family Planning - Women's Services</td>
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<td>Infertility</td>
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<tr>
<td>TMJ, Surgical and Non-Surgical</td>
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</table>

Includes surgical services, such as tubal ligation (excludes reversals)

Contraceptive devices as ordered or prescribed by a physician.

Infertility covered services: lab and radiology test, counseling, surgical treatment, and excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.

Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.

Unlimited maximum per lifetime.

Note: Services where plan deductible applies are noted with a caret (^).
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital Facility</th>
<th>Inpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lifesource Facility In-Network</td>
<td>Non-Lifesource Facility In-Network</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% †</td>
<td>Plan pays 80% †</td>
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<td></td>
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<td>Plan pays 100% †</td>
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</tbody>
</table>

- Travel Maximum - Lifesource Facility: In-Network: $15,000 maximum per Transplant

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient</th>
<th>Outpatient - Physician’s Office</th>
<th>Outpatient – All Other Services</th>
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</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>Plan pays 80% †</td>
<td>Plan pays 60% †</td>
<td>Plan pays 80% †</td>
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<tr>
<td>Substance Use Disorder</td>
<td>Plan pays 80% †</td>
<td>Plan pays 60% †</td>
<td>Plan pays 80% †</td>
</tr>
</tbody>
</table>

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

Notes: Detox is covered under medical.

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum
- Inpatient includes Residential Treatment
- Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization
## 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
- Narcotic Therapy Management
- Complex Psychiatric Case Management

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>In-Network</th>
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</table>

### Cost Share and Supply

**Cigna Pharmacy Cost Share**

- Retail – up to 90-day supply
- (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply

**Retail (per 30-day supply):**
- Generic: You pay 20%
- Preferred Brand: You pay 20%
- Non-Preferred Brand: You pay 20%

**Retail (per 90-day supply):**
- Generic: You pay 20%
- Preferred Brand: You pay 20%
- Non-Preferred Brand: You pay 20%

**Home Delivery (per 90-day supply):**
- Generic: You pay 20%
- Preferred Brand: You pay 20%
- Non-Preferred Brand: You pay 20%
### Pharmacy

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication.
- 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.

### 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.
- Preventive Generics at Retail or Home Delivery $0 copay.

### 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 - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
  - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
  - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
  - Utilization and Unit Cost Management - prior authorization, quantity limits, and maximum daily dose for limited class(es) of specific 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 Program Information

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)

- 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.

Cholesterol Lowering (STATIN)

- 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.

Heartburn/Ulcer (PPI)

- 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.

Bladder Problems (OAB)

- 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.

Osteoporosis (BONE)

- 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.

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)

- 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.
### Pharmacy Program Information

#### Depression (SSRI/SNRI)
- 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.

#### Skin Conditions (TI)
- 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.

#### 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)
- 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.

#### ADD/ADHD (ADHD)
- 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.

#### 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 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.
### 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.

**Comprehensive Oncology Program**  
- Care Management outreach  
- Case Management  
- Included

**Health Advisor - A**  
Support for healthy and at-risk individuals to help them stay healthy  
- Health Assessments  
- Health and Wellness Coaching  
- Gaps in Care Coaching  
- Treatment Decision Support  
- Educate and Refer  
- Included

**Healthy Pregnancies/Healthy Babies**  
- Care Management outreach  
- Maternity Case Management  
- Neo-natal Case Management  
- $150 (1st trimester) / $75 (2nd trimester) - Option 3

**Maximum Reimbursable Charge**  
Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (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.

- $500 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.

- $500 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

### Pre-Existing Condition Limitation (PCL)
**does not apply.**

### Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- **Condition Management**
- **Medication adherence**
- **Risk factor management**
- **Lifestyle issues**
- **Health & Wellness issues**
- **Pre/post-admission**
- **Treatment decision support**
- **Gaps in care**

<table>
<thead>
<tr>
<th>Holistic health support for the following chronic health conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Heart Disease</td>
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<td>- Coronary Artery Disease</td>
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<tr>
<td>- Angina</td>
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<tr>
<td>- Congestive Heart Failure</td>
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<tr>
<td>- Acute Myocardial Infarction</td>
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<tr>
<td>- Peripheral Arterial Disease</td>
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<tr>
<td>- Asthma</td>
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<tr>
<td>- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)</td>
</tr>
<tr>
<td>- Diabetes Type 1</td>
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<tr>
<td>- Diabetes Type 2</td>
</tr>
<tr>
<td>- Metabolic Syndrome/Weight Complications</td>
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<tr>
<td>- Osteoarthritis</td>
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<tr>
<td>- Low Back Pain</td>
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<tr>
<td>- Anxiety</td>
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<tr>
<td>- Bipolar Disorder</td>
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<tr>
<td>- Depression</td>
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</tbody>
</table>
Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

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

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

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

Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on the Schedule) without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies.
Exclusions

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: Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Craniocasral/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 12 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.

• For 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 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.

• 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 and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.

• Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

• Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

• Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.

• Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

• Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

• Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

• Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
Exclusions

- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- 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.
- 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.
- 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.
- 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.

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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EHB State: OH
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)
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）。


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


**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 плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**French Creole** – ATANSYON: Gen sèvis ed 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 bitte 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 شماره‌های که در پشت کارت شناسایی شما است تلفن 1.800.244.6224 (شماره تلفن ویژه ناشنوایان: شماره 711 شماره گیری کدی) تماس بگیرید.