BENEFIT SUMMARY

Cigna HealthCare of California, Inc.
For - City of San Diego
HMO
HMO
Effective - 08/01/2021

Selection of a Primary Care Provider - This Plan requires 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. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of 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
Lifetime Maximum	Unlimited
Coinsurance	Your plan pays 100%
Contract Year Deductible	Individual: None Family: None
Contract Year Out-of-Pocket Maximum	Individual: $1,500 Family: $3,000

- 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.
- In-Network covered expenses that count towards your out-of-pocket maximum include the member paid coinsurance and copays.

Benefit	In-Network
Physician Services	
Physician Office Visit • Plan pays 100% after you pay copay	$20 Primary Care Physician (PCP) copay or $20 Specialist copay
Surgery Performed in Physician's Office	$20 PCP or $20 Specialist copay
Allergy Treatment/Injections	$20 copay or actual charge (if less)
Allergy Serum Allergy serum dispensed by the physician in the office	Your plan pays 100%

Benefit	In-Network
Cigna Telehealth Connection Services (Virtual Care)	$20 copay
• 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) • Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person. • Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care section).	
Preventive Care	
Preventive Care	Your plan pays 100%
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	
Immunizations	Your plan pays 100%
Mammogram, PAP, and PSA Tests	Your plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Associated wellness exam is covered in-network only. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.	
Inpatient	
Inpatient Hospital Facility	$100 per admission copay
Semi-Private Room: Limited to the semi-private negotiated rate **Private Room:** Limited to the semi-private negotiated rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to the negotiated rate	
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 100%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%
Outpatient	
Outpatient Facility Services	$50 per facility visit copay
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%
Short-Term Rehabilitation	$20 PCP or $20 Specialist copay
Contract Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	

Benefit	In-Network
Chiropractic Care Contract Year Maximums: • Chiropractic Care - 40 days	$15 copay
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • 100 days maximum per Contract Year (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day	Your plan pays 100%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 100 days maximum per Contract Year	Your plan pays 100%
Durable Medical Equipment • Unlimited maximum per Contract Year	Your plan pays 100%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Your plan pays 100%
External Prosthetic Appliances (EPA) • Unlimited maximum per Contract Year	Your plan pays 100%
Routine Foot Disorders	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	
Acupuncture • 40 days maximum per Contract Year	$15 copay
Hearing Aid • $500 maximum per 36 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	Your plan pays 100%

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

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	In-Network	In-Network	In-Network
Lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Advanced Radiology Imaging	Plan pays 100%	Not Applicable	Plan pays 100%	Plan pays 100%

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	In-Network	In-Network
Emergency Care	$75 per visit (copay waived if admitted)	Plan pays 100%	Plan pays 100%
Urgent Care	$20 per visit (copay waived if admitted)	Plan pays 100%	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	In-Network
Hospice	Plan pays 100%	Plan pays 100%
Bereavement Counseling	Plan pays 100%	Plan pays 100%
Note: Services provided as part of Hospice Care Program		

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	In-Network	In-Network	In-Network
Maternity	$20 PCP or $20 Specialist copay	Plan pays 100%	$20 PCP or $20 Specialist copay	Covered same as plan's Inpatient Hospital benefit

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
Abortion (Elective and non-elective procedures)	$20 PCP or $20 Specialist copay	$100 per admission copay	$50 per facility visit copay	Plan pays 100%	Plan pays 100%
Family Planning - Men's Services	$20 PCP or $20 Specialist copay	$100 per admission copay	$50 per facility visit copay	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.					
Infertility	$20 PCP or $20 Specialist copay	$100 per admission copay	$50 per facility visit copay	Plan pays 100%	Plan pays 100%
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.					
Lifetime Limit: Unlimited					

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
TMJ, Surgical and Non-Surgical	$20 PCP or $20 Specialist copay	$100 per admission copay	$50 per facility visit copay	Plan pays 100%	Plan pays 100%
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.					

Benefit	Inpatient Hospital Facility	Inpatient Professional Services
	Cigna LifeSOURCE Transplant Network® Facility In-Network	Cigna LifeSOURCE Transplant Network® Facility In-Network
Organ Transplants	$100 per admission copay	Plan pays 100%
Travel Lifetime Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: $10,000 maximum per Transplant per Lifetime		

Benefit	Inpatient	Outpatient - Physician's Office	Outpatient – All Other Services
	In-Network	In-Network	In-Network
Mental Health	$100 per admission copay	$20 copay	Plan pays 100%
Substance Use Disorder	$100 per admission copay	$20 copay	Plan pays 100%

Note:

- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.

Mental Health and Substance Use Disorder Services

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

Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Plus Cost Share • Retail – up to 30-day supply • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $15 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $30 **Home Delivery (per 90-day supply):** Generic: You pay $30 Preferred Brand: You pay $60 Non-Preferred Brand: You pay $60
• Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • 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. • 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 (unless the physician indicates "Dispense As Written" DAW).	
Pharmacy Out-of-Pocket Maximum • Retail and Home Delivery cost share applies to the Pharmacy Out-of-Pocket.	Individual: $1,000 Family: $2,000
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: • Self Administered injectables are covered. • 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. • Oral Fertility drugs are covered.	

Pharmacy Program Information

Pharmacy Clinical Management: Essential

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

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

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

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; or (ii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Additional Information

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

Multiple Surgical Reduction
In-Network - does not apply.
Out-of-Network - 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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

Pre-Certification - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician

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

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

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

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - 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; provided, however, that this exclusion shall not operate to exclude coverage for services provided to a Member confined in a city or county jail or in a juvenile facility, solely because of such confinement, or for services provided to a Member while confined in a state hospital, solely because the services were provided in a state hospital.
- Services required by state or federal law to be supplied by a public school system or school district that are directed by or coordinated through the public school system or the school district rather than through a Participating Provider other than those services described under Section IV. Covered Services and Supplies, Autistic Disorders.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational and unproven services as defined in "Section I. Definitions of Terms Used in this Group Service Agreement."
- Cosmetic surgery or therapy except as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies."
- The following services are excluded unless Medically Necessary:
    - Macromastia or Gynecomastia Surgeries - Macromastia surgery is the surgical excision of enlarged female breast tissue, skin and fat in order to decrease the size of the breast. Gynecomastia surgery is a procedure to treat benign enlargement of the male breast;
    - Surgical treatment of varicose veins;
    - Abdominoplasty - Abdominoplasty, also referred to as a "tummy tuck" is a surgical procedure that tightens a lax anterior abdominal wall and removes excess abdominal skin (panniculectomy component). It is generally to improve appearance by recontouring the abdominal wall area;
    - Panniculectomy - Panniculectomy is the surgical excision of redundant panniculus adiposus (the superficial fascia which contains an abundance of fat tissue);
    - Rhinoplasty;
    - Blepharoplasty - Blepharoplasty refers to the surgical excision of redundant tissues (muscle, fat, skin) of the eyelids;
    - Redundant skin surgery;
    - Removal of skin tags.
- The following services are excluded from coverage regardless of clinical indications:
    - Acupressure;

Exclusions

- Craniosacral/cranial therapy - Craniosacral therapy (CST), also called cranial therapy, is an unproven non-invasive treatment that utilizes diagnostic touching to detect reported pulsations and rhythms of the flow of cerebrospinal fluid to effect a release of possible restrictions without the use of forceful manipulation. CST has been utilized for a variety of both musculoskeletal and general medical conditions. Some reported clinical applications of CST include acute systemic infections, chronic pain conditions, localized infection, dysfunctions of the viscera (e.g., ulcerative bowel conditions, asthma), depression, strabismus, auditory problems, developmental delay, and autism. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
- Dance therapy;
- Applied kinesiology - Applied kinesiology is a system using muscle testing as a functional neurological evaluation. The methodology is concerned primarily with neuromuscular function as it relates to the structural, chemical and mental physiologic regulatory mechanisms. A.K., which originated within the chiropractic profession, is an approach to clinical practice, with multidisciplinary applications. The safety and efficacy of this technique has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
- Rolfing;
- Prolotherapy - Prolotherapy is the injection of a solution for the purpose of tightening and strengthening loose or weak tendons, ligaments or joint capsules through the multiplication and activation of fibroblasts. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"; and
- Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions - Extracorporeal shock wave therapy (ESWL) is a noninvasive treatment that involves delivery of 1000 to 3000 shock waves to the painful musculoskeletal region, and has been proposed as an alternative to surgery. The mechanism by which ESWL might work to relieve pain associated is unknown and the efficacy has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least fifty (50%) percent bony support and are functional in the arch.
- Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based scientific literature and scientifically-based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - 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, unless Medically Necessary or as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies"; and
  - Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV.

Exclusions

Covered Services and Supplies."

- Reversal of male and female voluntary sterilization procedures.
- Treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation. However, Medically Necessary treatment and penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services including but not limited to, Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs and driving safety. Behavioral training and services, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation are also excluded except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies."
- Consumable medical supplies other than ostomy supplies, urinary catheters and diabetic supplies. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies including skin preparations, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Diabetic Services", "Diabetic Supply Coverage", "Durable Medical Equipment" and "Home Health Services", sections of "Section IV. Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies." or unless determined to be Medically Necessary by the Healthplan Medical Director in consultation with the Member's treating Physician.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids including, but not limited to, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Corrective orthopedic shoes, unless medically necessary or as specified in the "Orthoses and Orthotic Devices" section of "Section IV. Covered Services and Supplies".
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Routine refraction.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All prescription drugs, non-prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, and investigational and experimental drugs (except as specified in "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"), and "Section IV. Covered Services and Supplies."
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Dental implants for any condition.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease, except as provided in the "Genetic Testing" section of "Section IV. Covered Services and Supplies."
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.

Exclusions

- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism and as specified under the "Phenylketonuria (PKU) Testing and Treatment" provision of Section IV. Covered Services and Supplies.
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement 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.

EHB State: CA

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 LƯU 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 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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 ناشنوایان: شماره 711 را شماره‌گیری کنید).