

## SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.  
For - City of San Diego  
Open Access Plus (Plan D3O) Plan



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

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

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Coinsurance</b>	Your plan pays 80%	Your plan pays 60%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Calendar Year Deductible</b>	Individual: \$500 Family: \$1,500	Individual: \$500 Family: \$1,500
<ul style="list-style-type: none"><li>Only the amount you pay for in-network covered expenses counts toward your in-network deductible. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network deductible.</li><li>Copays always apply before plan deductible and coinsurance.</li><li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li></ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

Plan Highlights		In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum		Individual: \$3,000 Family: \$9,000	Individual: \$6,000 Family: \$18,000
<ul style="list-style-type: none"><li>Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li><li>Plan deductible does not contribute towards your out-of-pocket maximum.</li><li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li><li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li><li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li><li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li><li>Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.</li></ul>			
Benefit		In-Network	Out-of-Network
Physician Services			
Physician Office Visit – Primary Care Physician (PCP)/Specialist <ul style="list-style-type: none"><li>All services including Lab &amp; X-ray</li></ul>		\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
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)			
Surgery Performed in Physician’s Office		\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
Allergy Treatment/Injections Performed in Physician's Office		\$25 copay, then your plan pays 100% or actual charge (if less)	After the plan deductible is met, your plan pays 60%
Allergy Serum <ul style="list-style-type: none"><li>Dispensed by the physician in the office</li></ul>		Your plan pays 100%	After the plan deductible is met, your plan pays 60%
Cigna Telehealth Connection Services <ul style="list-style-type: none"><li>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)</li><li>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.</li></ul>		\$25 copay, then your plan pays 100%	Not Covered
Preventive Care			
Preventive Care Birth through age 16		Plan pays 100%	After the plan deductible is met, your plan pays 60%
Ages 17 and older <ul style="list-style-type: none"><li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li></ul>		Plan pays 100%	Not Covered

Benefit	In-Network	Out-of-Network
<b>Immunizations</b> Birth through age 16 Ages 17 and older	Plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Mammogram, PAP, and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Associated wellness exam is covered in-network only.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	Plan pays 100%	Not Covered Plan pays based on place of service.
<b>Inpatient</b>		
<b>Inpatient Hospital Facility</b>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Outpatient</b>		
<b>Outpatient Facility Services</b>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Short-Term Rehabilitation - PCP</b>	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Short-Term Rehabilitation - Specialist</b>	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Calendar Year Maximums:</b> <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 20 days</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</li> </ul>		
<b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Chiropractic Care - PCP</b>	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%

Benefit	In-Network	Out-of-Network
<b>Chiropractic Care - Specialist</b> <ul style="list-style-type: none"> <li>Chiropractic Care – \$1,500 maximum per calendar year</li> </ul> <b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Cardiac Rehabilitation</b> <ul style="list-style-type: none"> <li>Cardiac Rehabilitation – 36 days</li> </ul> <b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>100 days maximum per Calendar Year (The limit is not applicable to mental health and substance use disorder conditions.)</li> <li>16 hour maximum per day</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>100 days maximum per Calendar Year</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>	Your plan pays 100%	Not Covered
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Routine Foot Disorders</b>	Not Covered	Not Covered
<b>Acupuncture</b> <ul style="list-style-type: none"> <li>20 days maximum per Calendar Year</li> </ul>	\$25 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 60%

Benefit	In-Network	Out-of-Network
<b>Medical Specialty Drugs</b>		
<b>Inpatient</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<b>Physician's Office</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	Your plan pays 100%	After the plan deductible is met, your plan pays 60%
<b>Home</b> <ul style="list-style-type: none"> <li>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.</li> </ul>	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 (^).**

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Laboratory</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 80% ^	Plan pays 60% ^
<b>Radiology</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 80% ^	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 (^).

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Advanced Radiology Imaging</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Emergency Care</b>	\$100 per visit (copay waived if admitted) ^, then your plan pays 100%		Plan pays 100% ^		Plan pays 80% ^	
<b>Urgent Care</b>	\$25 per visit ^, your plan pays 80%	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Not Applicable*	

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

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Hospice</b>	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
<b>Bereavement Counseling</b>	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^

Note: Services provided as part of Hospice Care Program

- Hospice is provided to members with a life expectancy of 6 months or less.

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

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

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

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Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Abortion</b> (Elective and non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
<b>Family Planning - Men's Services</b>	Covered same as plan's Physician's Office Services	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered
<b>Family Planning - Women's Services</b>	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
<b>Infertility</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. \$10,000 lifetime maximum										
<b>TMJ, Surgical and Non-Surgical</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
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 (^).										



Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifefsource Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifefsource Facility In-Network	Out-of-Network
<b>Organ Transplants</b>	Plan pays 100%	Plan pays 80% ^	Not Covered	Plan pays 100%	Plan pays 80% ^	Not Covered
<ul style="list-style-type: none"> <li>Travel Lifetime Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: \$10,000 maximum per Transplant per Lifetime</li> </ul>						
Note: Services where plan deductible applies are noted with a caret (^).						
Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Mental Health</b>	Plan pays 80% ^	Plan pays 60% ^	\$25 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
<b>Substance Use Disorder</b>	Plan pays 80% ^	Plan pays 60% ^	\$25 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Note: Services where plan deductible applies are noted with a caret (^).						
<b>Notes:</b> Detox is covered under medical. <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> <li>Services are paid at 100% after you reach your out-of-pocket maximum</li> <li>Inpatient includes Residential Treatment</li> <li>Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization</li> </ul>						
<b>Mental Health and Substance Use Disorder Services</b>						
<b>Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs</b> Cigna Total Behavioral Health - Inpatient and Outpatient Management <ul style="list-style-type: none"> <li>Inpatient utilization review and case management</li> <li>Outpatient utilization review and case management</li> <li>Partial Hospitalization</li> <li>Intensive outpatient programs</li> <li>Changing Lives by Integrating Mind and Body Program</li> <li>Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.</li> <li>Narcotic Therapy Management</li> <li>Complex Psychiatric Case Management</li> </ul>						



Pharmacy	In-Network	Out-of-Network
<b>Cigna Pharmacy Plus three-tier copay plan</b> <ul style="list-style-type: none"> <li>Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.</li> <li>When patient requests brand drug, patient pays the generic copay plus the cost difference between the brand and generic drugs up to the cost of the brand drug.</li> <li>Your pharmacy benefits have a combined out-of-pocket maximum with the medical/behavioral benefits.</li> <li>Self Administered injectable drugs are covered</li> <li>Oral contraceptives included</li> <li>Includes oral contraceptives - with specific products covered 100%</li> <li>Lifestyle drugs included - limited to sexual dysfunction</li> <li>Oral Fertility drugs included</li> <li>Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges included.</li> <li>Specialty medications are limited to a 30-day supply</li> </ul>	<b>Retail</b> - 30 day supply Generic: You pay \$15 Preferred Brand: You pay \$30 Non-Preferred Brand: You pay \$30  <b>Home delivery</b> - 90 day supply Generic: You pay \$30 Preferred Brand: You pay \$60 Non-Preferred Brand: You pay \$60	Not Covered
<b>Pharmacy Program Information</b>		
<b>Pharmacy Clinical Management and Prior Authorization</b> <ul style="list-style-type: none"> <li>Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.</li> <li>Plan exclusion edits are always included.</li> <li>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: <ul style="list-style-type: none"> <li>Benefits Exclusion - prior authorization, age edits and quantity over time edits.</li> <li>Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.</li> <li>Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.</li> </ul> </li> </ul>		
<b>Prescription Drug List:</b> <ul style="list-style-type: none"> <li>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 <a href="http://myCigna.com">myCigna.com</a>.</li> </ul>		
<b>Specialty Pharmacy Management:</b> <ul style="list-style-type: none"> <li>Clinical Programs <ul style="list-style-type: none"> <li>Prior authorization is required on specialty medications and quantity limits may apply.</li> <li>Theracare® Program</li> </ul> </li> <li>Medication Access Option <ul style="list-style-type: none"> <li>Retail and/or Home Delivery</li> </ul> </li> </ul>		
<b>Pharmacy Cost Management Program</b> <b>Step Therapy</b> is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered. <ul style="list-style-type: none"> <li>All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step</li> </ul>		

## Pharmacy Program Information

Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

High Blood Pressure (ACEI/ARB), Cholesterol Lowering (STATIN), Heartburn/Ulcer (PPI), Bladder Problems (OAB), Osteoporosis (Bone), Non-Narcotic Pain relievers (NSAID), ADD/ADHD (ADHD), Allergy (Nasal Steroids), Depression (SSRI/SNRI)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

Sleep Disorders (HYPNOTICS), Mental Health (ATYPICAL PSYCHS), Asthma (ASTHMA)

- Generic or PB First One Step – Step 1 (Generic) or Step 2 (Preferred Brand) medications must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

Skin Conditions (TI), Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

### Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

## 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)

## Additional Information

### 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

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

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

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% 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 - 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.

- 50% 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.

## Additional Information

### 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** - 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.

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## Exclusions

- Treatment of an Injury or Sickness which is due to war, declared or undeclared.
- 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.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section 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 or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Cosmetic surgery and therapy does not include gender reassignment services.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics (unless services are an integral part of reconstructive surgery for Cleft Palate), periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- 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 appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational

## Exclusions

- 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 nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
  - Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
  - Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
  - All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
  - Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
  - Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
  - Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
  - Dental implants for any condition, unless services are an integral part of reconstructive surgery for Cleft Palate.
  - 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 nonparticipating provider.
  - Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
  - For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
  - Massage therapy.

### These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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# 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](mailto: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](mailto: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 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**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 deyè 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).