SUMMARY OF BENEFITS

Connecticut General Life Insurance Co.
For - Arlington County School Board
Open Access Plus - High Option Plan

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

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 90%	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable	80th Percentile
Calendar Year Deductible	Individual: $300 Family: $600	Individual: $750 Family: $1,500

- 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.
- Copays always apply before plan deductible and coinsurance.
- 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.

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

Calendar Year Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $3,750 Family: $7,500

- 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.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Physician Services		
Physician Office Visit – Primary Care Physician (PCP) • All services including Lab & X-ray	$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 70%
Physician Office Visit – Specialist • All services including Lab & X-ray	$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 70%
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 - PCP	$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 70%
Surgery Performed in Physician's Office – Specialist	$40 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 70%
Allergy Treatment/Injections Performed in Physician's Office PCP	$20 copay, then your plan pays 100% or actual charge (if less)	After the plan deductible is met, your plan pays 70%
Allergy Treatment/Injections Performed in Specialist Office	$40 copay, then your plan pays 100% or actual charge (if less)	After the plan deductible is met, your plan pays 70%
Allergy Serum - PCP	Your plan pays 100%	After the plan deductible is met, your plan pays 70%
Allergy Serum - Specialist • Dispensed by the physician in the office	Your plan pays 100%	After the plan deductible is met, your plan pays 70%
Cigna Telehealth Connection services	$20 copay, then your plan pays 100%	Not Covered
• 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)		
Preventive Care		
Preventive Care • 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. • Includes well-baby, well-child, adult and well-woman preventive.	Plan pays 100%	PCP: After the plan deductible is met, your plan pays 70% Specialist: After the plan deductible is met, your plan pays 70%
Immunizations	Plan pays 100%	PCP: After the plan deductible is met, your plan pays 70% Specialist: After the plan deductible is met, your plan pays 70%

Benefit	In-Network	Out-of-Network
Mammogram, PAP, and PSA Tests	Plan pays 100%	Plan pays based on place of service.
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. • Preventive mammogram paid at 100%, no deductible for In-Network and Out-of-Network		
Inpatient		
Inpatient Hospital Facility	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible.	$100 per facility visit copay and plan deductible, then your plan pays 90%	$100 per facility visit deductible and plan deductible, then your plan pays 70%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Early Intervention Services	$20 PCP or $40 Specialist copay	Your plan pays 70% ^
Short-Term Rehabilitation - PCP	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Short-Term Rehabilitation - Specialist	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Calendar Year Maximums: • Pulmonary Rehabilitation and Physical Therapy - Combined 75 days • Cognitive Therapy – 40 days • Speech Therapy and Occupational Therapy – Unlimited days • Chiropractic Care - Unlimited days • Cardiac Rehabilitation - 90 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. 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	Out-of-Network
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity)	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
• 120 days maximum per Calendar Year (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 120 days maximum per Calendar Year	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 100%	After the plan deductible is met, your plan pays 70%
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%	After the plan deductible is met, your plan pays 70%
External Prosthetic Appliances (EPA)	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
• Unlimited maximum per Calendar Year		
Routine Foot Disorders	Not Covered	Not Covered
• Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
Nutritional Supplements	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Blood and Blood Product Fees Subject to medical necessity	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Acupuncture Performed in Physician's Office - PCP	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
Acupuncture Performed in Physician's Office - Specialist	After the plan deductible is met, your plan pays 90%	After the plan deductible is met, your plan pays 70%
• Unlimited days maximum per Calendar Year • Limited to pain relief, nausea due to chemotherapy or radiation, and hyperemesis of pregnancy.		
Wigs • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 100%

Benefit	In-Network	Out-of-Network
Medical Specialty Drugs		
Inpatient • 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 90%	After the plan deductible is met, your plan pays 70%
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 90%	After the plan deductible is met, your plan pays 70%
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.	Your plan pays 100%	After the plan deductible is met, your plan pays 70%
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 90%	After the plan deductible is met, your plan pays 70%

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
Laboratory	$20 PCP or $40 Specialist copay	Plan pays 70%^	Plan pays 100%	Plan pays 70%^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 100%	Plan pays 70%^
Radiology	$20 PCP or $40 Specialist copay	Plan pays 70%^	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 100%	Plan pays 70%^

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
Advanced Radiology Imaging	$100 copay per type of scan per day	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	$100 copay per type of scan per day	$100 copay per type of scan per day	$100 copay per type of scan per day; then plan pays 90% ^	Covered same as plan's Outpatient Facility Services

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Per scan copays are in addition to Physician's Office Services, ER/UC Facility and OP facility charges
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$200 per visit (copay waived if admitted) then your plan pays 100%		Plan pays 100% ^		Plan pays 90% ^	
Urgent Care	$50 per visit, then your plan pays 100%		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	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
Bereavement Counseling	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^

Note: Services provided as part of Hospice Care Program

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

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90% ^	Plan pays 70% ^	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 (^).

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Elective and non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible, after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible, after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	$250 per admit deductible and plan deductible, then your plan pays 70%	Plan pays 100%	$100 per facility visit deductible, after plan deductible, then your plan pays 70%	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible, after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.										

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
TMJ, Surgical and Non-Surgical	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible, after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime										
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of injury to sound natural teeth	$20 PCP or $40 Specialist copay	Plan pays 70% ^	$250 per admission copay and plan deductible, then your plan pays 90%	$250 per admission deductible and plan deductible th en your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Bariatric Surgery	$20 PCP or $40 Specialist copay	Plan pays 70% ^	$250 per admission copay and plan deductible, then your plan pays 90%	$250 per admission copay and plan deductible, then your plan pays 70%	$100 per facility visit copay after plan deductible, then your plan pays 90%	$100 per facility visit deductible after plan deductible, then your plan pays 70%	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Surgeon Charges Lifetime Maximum: Unlimited										
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are 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. • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision										
Note: Services where plan deductible applies are noted with a caret (^).										

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	$250 per admission copay	$250 per admit copay and plan deductible, then your plan pays 90%	$250 per admit deductible and plan deductible, then your plan pays 70%	Plan pays 100%	Plan pays 90% ^	Plan pays 70% ^

- Travel Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant

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

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	$250 per admission copay, then plan pays 90% ^	$250 per admission deductible, then plan pays 70% ^	$20 copay	Plan pays 70% ^	No charge ^	Plan pays 70% ^
Substance Use Disorder	$250 per admission copay, then plan pays 90% ^	$250 per admission deductible, then plan pays 70% ^	$20 copay	Plan pays 70% ^	No charge ^	Plan pays 70% ^

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
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
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 $4 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $45 **Retail and Home Delivery (per 90-day supply):** Generic: You pay $0 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $90	**Retail (per 30 day supply):** Generic: You pay $4 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $45 **Home Delivery:** Not Covered

- 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: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.
- 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.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 3 Retail fill.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- 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.

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, maximum daily dose, and step therapy 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 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.

<u>High Blood Pressure (ACEI/ARB)</u>

- 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.

<u>Cholesterol Lowering (STATIN)</u>

- 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.

<u>Heartburn/Ulcer (PPI)</u>

- 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.

<u>Bladder Problems (OAB)</u>

- 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.

<u>Osteoporosis (BONE)</u>

- 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.

Pharmacy Program Information

- 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.

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.

Pharmacy Program Information

- 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.

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 percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. 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.**

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.

Additional Information

Personal Health Team - A Client specific team of clinical specialists who provide support for healthy, at-risk and acute care individuals to help them stay healthy • Health and Wellness Coaching • Cigna Well Informed Program • Preference Sensitive Care • Behavioral Health Case Management • 24 hour Health Information Line Outreach • Pre Admission Outreach • Post Discharge Outreach • Inpatient Advocacy • Case Management - Short term and complex	Care Facility - N/A

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.

- 20% 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.

- 20% 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.

Exclusions

- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; 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, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound 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.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
- Reversal of male and female voluntary sterilization procedures.
- Any services, supplies, medications or drugs 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 the Agreement.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services.
- 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 "Outpatient Facility Services," "Home Health Services" sections of "Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies".
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary

Exclusions

meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, 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, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Dental implants for any condition.
- 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.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- 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.
- Telephone, e-mail, and Internet consultations, and telemedicine.

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.

EHB State: VA

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).