

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
<ul style="list-style-type: none">Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan. <p>Note: Services where plan deductible applies are noted with a caret (^)</p>		

1/1/2017

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Open Access Plus High Option - Copay Plan - 5309494. Version# 7

Plan Highlights		In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum		Individual: \$3,000 Family: \$6,000	Individual: \$3,750 Family: \$7,500
<ul style="list-style-type: none">Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. 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.Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.			
Benefit	In-Network	Out-of-Network	
Note: Services where plan deductible applies are noted with a caret (^)			
Physician Services			
Surgery Performed in Physician's Office	\$20 PCP or \$40 Specialist copay	Your plan pays 70% ^	
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none">All services including Lab & X-rayPlan pays 100% after you pay copay	\$20 Primary Care Physician (PCP) copay or \$40 Specialist copay	Your plan pays 70% ^	
Allergy Treatment/Injections	\$20 PCP or \$40 Specialist copay or actual charge (if less)	Your plan pays 70% ^	
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 70% ^	
Preventive Care			
Routine Preventive Care - All Ages <ul style="list-style-type: none">Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.Includes well-baby, well-child, adult and well-woman preventive.	Your plan pays 100%	Your plan pays 70% ^	
Immunizations - All Ages	Your plan pays 100%	Your plan pays 70% ^	
Mammogram, PAP, and PSA Tests <ul style="list-style-type: none">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.Mammogram paid at 100% No deductible In and Out of Network	Your plan pays 100%	Your plan pays 70% ^	
Inpatient			

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Hospital Facility	\$250 per admission copay, then your plan pays 90% ^	\$250 per admission 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	Your plan pays 90% ^	Your plan pays 70% ^
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient		
Outpatient Facility Services <ul style="list-style-type: none"> Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible 	\$100 per facility visit copay, then your plan pays 90% ^	\$100 per facility visit deductible, then your plan pays 70% ^
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 90% ^	Your plan pays 70% ^
Early Intervention Services	\$20 PCP or \$40 Specialist copay	Your plan pays 70% ^
Short-Term Rehabilitation	Your plan pays 90% ^	Your plan pays 70% ^
Calendar Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation and Physical Therapy - Combined 75 days Cognitive Therapy – 40 days Speech Therapy and Occupational Therapy – Unlimited days Chiropractic Care - Unlimited days 		
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Cardiac Rehabilitation - 90 days	Your plan pays 90% ^	Your plan pays 70% ^
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> 120 days maximum per Calendar Year 16 hour maximum per day 	Your plan pays 90% ^	Your plan pays 70% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility <ul style="list-style-type: none"> 120 days maximum per Calendar Year 	Your plan pays 90% ^	Your plan pays 70% ^

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Benefit		In-Network		Out-of-Network				
Note: Services where plan deductible applies are noted with a caret (^)								
Durable Medical Equipment <ul style="list-style-type: none">Unlimited maximum per Calendar Year		Your plan pays 100% ^		Your plan pays 70% ^				
Breast Feeding Equipment and Supplies <ul style="list-style-type: none">Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.Includes related supplies		Your plan pays 100%		Your plan pays 70% ^				
External Prosthetic Appliances (EPA) <ul style="list-style-type: none">Unlimited maximum per Calendar Year		Your plan pays 90% ^		Your plan pays 70% ^				
Routine Foot Disorders		Not Covered		Not Covered				
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.								
Nutritional Supplements		Your plan pays 90% ^		Your plan pays 70% ^				
Blood and Blood Product Fees Subject to medical necessity		Your plan pays 90% ^		Your plan pays 70% ^				
Acupuncture <ul style="list-style-type: none">Limited to pain relief, nausea due to chemotherapy or radiation, and hyperemesis of pregnancy		Your plan pays 90% ^		Your plan pays 70% ^				
Wigs <ul style="list-style-type: none">\$350 maximum per Calendar Year		Your plan pays 100%		Your plan pays 100%				
Place of Service - your plan pays based on where you receive services								
Note: Services where plan deductible applies are noted with a caret (^)								
Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100% ^		Plan pays 100%	Plan pays 70% ^
Advanced Radiology Imaging	\$100 copay per type of scan per day	Plan pays 70% ^	Not Applicable	Not Applicable	\$100 copay per type of scan per day ^		\$100 copay per type of scan per day; then plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc...								
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit								

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network				
Emergency Care	\$200 per visit (copay waived if admitted) ^		Plan pays 100% ^		Plan pays 90% ^					
Urgent Care	\$50 per visit (copay waived if admitted) ^		Plan pays 100% ^		Not Applicable					
*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.										
Benefit	Inpatient Hospital and Other Health Care Facilities			Outpatient Services						
	In-Network		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	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	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
Note: Services where plan deductible applies are noted with a caret (^)										
Abortion (Elective and non-elective procedures)	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Family Planning - Men's Services	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)										

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
Note: Services where plan deductible applies are noted with a caret (^)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	\$250 per admission deductible, then plan pays 70% ^	Plan pays 100%	\$100 per facility visit deductible, then 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	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then 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.										
TMJ, Surgical and Non-Surgical	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then 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, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^

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
Note: Services where plan deductible applies are noted with a caret (^)										
Bariatric Surgery	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$100 per facility visit copay, then plan pays 90% ^	\$100 per facility visit deductible, then 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:										
<ul style="list-style-type: none">• medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.• weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision										
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 admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	Plan pays 100%	Plan pays 90% ^	Plan pays 70% ^				
<ul style="list-style-type: none">• Travel Lifetime Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant per Lifetime										
Note: Services where plan deductible applies are noted with a caret (^)										
Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network				
Mental Health	\$250 per admission copay, then plan pays 90% ^	\$250 per admission deductible, then plan pays 70% ^	\$20 copay	Plan pays 70% ^	Plan pays 100% ^	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% ^	Plan pays 100% ^	Plan pays 70% ^				
Note: Services where plan deductible applies are noted with a caret (^)										
Note: Detox is covered under medical										
<ul style="list-style-type: none">• Unlimited maximum per Calendar Year• Services are paid at 100% after you reach your out-of-pocket maximum.• Inpatient includes Residential Treatment.• Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.										

Mental Health and Substance Use Disorder Services

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

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

Cigna Pharmacy three-tier copay plan

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Patient is responsible for the applicable copay based upon the tier of the dispensed medication.
- Your pharmacy benefits have a combined out-of-pocket maximum with the medical/behavioral benefits.
- Self Administered injectable and optional injectable drugs - excludes infertility drugs
- Oral contraceptives included
- Includes oral contraceptives - with specific products covered 100%
- Lifestyle drugs included - limited to sexual dysfunction
- Prescription smoking cessation drugs included
- Prescription vitamins included
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included
- Mandatory home delivery: Maintenance medications, including oral contraceptives, must be filled through home delivery; otherwise after 3 retail fills you pay the entire cost of the prescription
- Specialty medications are limited to a 102-day supply for Home Delivery
- Specialty medications are limited to a 34-day supply at Retail

In-Network

Retail - 34 day supply

Generic: You pay \$4
Preferred Brand: You pay \$25
Non-Preferred Brand: You pay \$45

Home delivery - 102 day supply

Generic: You pay \$0
Preferred Brand: You pay \$50
Non-Preferred Brand: You pay \$90

Out-of-Network

Retail - 34 day supply

Generic: You pay \$4
Preferred Brand: You pay \$25
Non-Preferred Brand: You pay \$45

Home Delivery

Not 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.

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.

Specialty Pharmacy Management:

- Clinical Programs
 - Prior authorization is required on specialty medications but quantity limits may apply.
 - Theracare® Program
- Medication Access Option
 - Home Delivery Only (limited to 1 fill at Retail)

Pharmacy Cost Management Program

Step Therapy 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.

- 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 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.
- Some Step 3 (Non-Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

High Blood Pressure (ACEI/ARB)

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

Cholesterol Lowering (STATIN)

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

Heartburn/Ulcer (PPI)

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

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Pharmacy Program Information

Bladder Problems (OAB)

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

Osteoporosis (Bone)

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

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period

Pharmacy Program Information

- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 60 Days grace period
- First Fill Pay and Educate included

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.
- 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.

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.

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 - Preferred Care Management - 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 - Preferred Care Management - 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.

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

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

Exclusions

What's Not Covered (not all-inclusive):

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.

Exclusions

- 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 for learning disabilities, developmental delays, autism 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 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

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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.

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