# ATTACHMENT 1: CIGNA CDHP MEDICAL AND RX SCHEDULE OF BENEFITS

# CLIENT SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**
**For - City of Naples**
**Choice Fund Open Access Plus HRA Plan**

| **Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the calendar year.** | |
|---|---|
| **Employer Contribution** | Employee - $750<br>Employee + 1 - $1,250<br>Family - $1,500 |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Coinsurance** | Plan pays 80% coinsurance | Plan pays 50% coinsurance |
| **Maximum Reimbursable Charge**<br>Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (110%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. | Not Applicable | 110% |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Contract Year Deductible**<br>• The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.<br>• All eligible family members contribute towards the Individual + 1 or family plan deductible. The plan cannot pay an individual's claims until the total Individual + 1 or family deductible has been met, even if he or she has met the individual deductible.<br>• Retail and home delivery pharmacy costs contribute to the combined medical/pharmacy deductible. | Individual: $1,500<br>Individual + 1: $2,250<br>Family: $3,000 | Individual: $3,000<br>Individual + 1: $4,500<br>Family: $6,000 |
| **Contract Year Out-of-Pocket Maximum**<br>• The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.<br>• Plan Deductibles contribute towards your out-of-pocket maximum.<br>• Mental health and substance abuse covered expenses contribute towards your out-of-pocket maximum.<br>• All eligible family members contribute towards the Individual + 1 or Family out-of-pocket maximum. The plan cannot pay an individuals covered expenses at 100% until the total Indvidual +1 or Family out-of-pocket maximum has been reached.<br>• This plan includes a combined Medical/Rx out-of-pocket maximum.<br>• Mail order pharmacy costs contribute to the out-of-pocket maximum. | Individual: $3,000<br>Individual + 1: $4500<br>Family: $6,000 | Individual: $6,000<br>Individual + 1:$9,000<br>Family: $12,000 |
| **Pre-Existing Condition Limitation (PCL)** | Not applicable to anyone under 19 years old<br><br>PCL applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details. | |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Pre-certification - Continued Stay Review - PHS+ Inpatient** - required for all inpatient admissions | Coordinated by your physician | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.<br>• 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.<br>• Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.<br>• 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 | Coordinated by your physician | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.<br>• 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.<br>• Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified. |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Physician Services** | | |
| **Primary Care Physician (PCP) Office Visit** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Specialty Care Physician Office Visit** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Surgery Performed in Physician's Office** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Allergy Treatment/Injections** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Physician Services** | | |
| **Allergy Serum**<br>Dispensed by the physician in the office | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Preventive Care** | | |
| **Routine Preventive Care - All Ages**<br>• Includes well-baby, well-child, well-woman and adult preventive care<br>• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. | Plan pays 100%, no plan deductible | Children age 0-15 :<br>Plan pays 50% coinsurance and plan deductible is waived<br><br>Adults and children age 16 and older:<br>Plan pays 50% coinsurance after plan deductible is met |
| **Immunizations - All Ages** | Plan pays 100%, no plan deductible | Children age 0-15 :<br>Plan pays 50% coinsurance and plan deductible is waived<br><br>Adults and children age 16 and older:<br>Plan pays 50% coinsurance after plan deductible is met |
| **Mammogram, PAP, PSA Tests**<br>• Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | Plan pays 100%, no plan deductible | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Inpatient** | | |
| **Inpatient Hospital Facility**<br><br>**Semi-Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**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 | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Inpatient** | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **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. | |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Outpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Short-Term Rehabilitation**<br>Per Contract Year Maximums:<br>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 60 days<br>• Cardiac Rehabilitation - 36 days<br><br>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care**<br>(includes outpatient private duty nursing days when approved as medically necessary)<br>• 60 days maximum per Contract Year<br>• 16 hour maximum per day | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility**<br>• 60 days maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Other Health Care Facilities/Services** | | |
| **Durable Medical Equipment**<br>• Unlimited maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.<br>• Includes related supplies | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met |
| **External Prosthetic Appliances (EPA)**<br>• Unlimited maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Routine Foot Disorders** | Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. | Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. |
| **Rhinoplasty**<br>• Subject to Medical Necessity | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Wigs Maximum 2 per lifetime**<br>• Subject to Medical Necessity | Plan pays 80% coinsurance after the plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

**Place of Service - You pay based on where you receive services.**

| Benefit | Physician's Office | | Outpatient Facility | | Emergency Room/ Urgent Care Facility | | Independent Lab | | Inpatient Hospital | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 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 |
| **X-ray** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| **Lab** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 70% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician's Office** | | **Outpatient Facility** | | **Emergency Room/ Urgent Care Facility** | | **Independent Lab** | | **Inpatient Hospital** | |
| | **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** |
| **Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Not Applicable | Not Applicable | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician's Office** | | **Emergency Room** | | **Outpatient Professional Services (Radiologist, Pathologist, ER Physician)** | | ***Ambulance** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Emergency Care** | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | |
| * - Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician's Office** | | **Urgent Care Facility** | | **Outpatient Professional Services** | | ***Ambulance** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Urgent Care** | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | |
| * - Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Initial Visit to Confirm Pregnancy** | | **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** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services. | | | | |
|---|---|---|---|---|
| **Benefit** | **Inpatient Hospital and Other Health Care Facilities** | | **Outpatient Services** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Hospice (provided as part of Hospice Care Program)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Bereavement Counseling (Services provided as part of Hospice Care Program)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **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) | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician' s Services - Office Visit** | | **Inpatient Hospital Facility** | | **Outpatient Facility Services** | | **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** |
| **Family Planning - Men's Services** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Includes surgical services, such as vasectomy (excludes reversals). | | | | | | | | | | |
| **Family Planning - Women's Services** | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met |
| Includes surgical services, such as tubal ligation (excludes reversals). | | | | | | | | | | |
| Contraceptive devices as ordered or prescribed by a physician. | | | | | | | | | | |
| **Infertility** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. | | | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | |
|---|---|---|---|---|---|---|
| **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** | Plan pays 100% after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Not covered | Plan pays 100% after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Not covered |
| Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician' s Services - Office Visit** | | **Inpatient Hospital Facility** | | **Outpatient Facility Services** | | **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** |
| **Dental Care** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. | | | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **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** - case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Non-Surgical: Unlimited maximum per lifetime | | | | | | | | | | |

## Place of Service - You pay based on where you receive services.

| Benefit | Physician' s Services - Office Visit | | Inpatient Hospital Facility | | Outpatient Facility Services | | 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 |
| **Bariatric Surgery** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |

## Place of Service - You pay based on where you receive services.

| Benefit | Inpatient | | Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health) | | Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health) | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Mental Health** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

- Unlimited maximum per contract year
- Mental Health services are paid at 100% after you reach your out-of-pocket maximum

## Place of Service - You pay based on where you receive services.

| Benefit | Inpatient | | Outpatient - Physician's Office (includes individual and intensive outpatient substance abuse) | | Outpatient Facility (includes individual and intensive outpatient substance abuse) | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Substance Abuse** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

**Note:** Detox is covered under medical

- Unlimited maximum per contract year
- Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum

## Mental Health and substance abuse services

**MH/SA Service Specific Administration**

Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- Partial Hospitalization: The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- Standard for Residential Treatment: Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management.
- Intensive Outpatient Program (IOP): Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.

## Mental Health and substance abuse services

**Mental Health/Substance Abuse Utilization Review, Case Management and Programs**

Cigna Behavioral Advantage - 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: Strength and Resilience, Quit Today and Healthy Steps to Weight Loss.
- Narcotic Therapy Management

| Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| **Cigna Pharmacy three-tier coinsurance plan**<br>• Patient is responsible for the applicable coinsurance based upon the tier of the dispensed medication.<br>• Self Administered injectable drugs - excludes infertility drugs<br>• Oral Contraceptives included<br>• Includes Oral Contraceptives - with specific products covered 100%<br>• Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included | **Retail** - 30 day supply<br>Generic: You pay 30%<br>Preferred Brand: You pay 40%<br>Non-Preferred Brand: You pay 50%<br><br>**Home delivery** - 90 day supply<br>Generic: You pay 30%<br>Preferred Brand: You pay 40%<br>Non-Preferred Brand: You pay 50% | **Retail**<br>You pay 50%<br>Plan pays 50%<br><br>**Home Delivery**<br>You pay 50%<br>Plan pays 50% |

**Pharmacy Clinical Management and Prior Authorization**

- Your plan is subject to certain clinical edits and prior authorization requirements
- Refill-too-soon and 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.

**Specialty Pharmacy Management:**

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
- Medication Access Option
  - Retail and/or Home Delivery

## Additional Information

**Prescription Drug List:**

- Cigna Standard Prescription Drug List

## Health and Wellness Programs

| | |
|---|---|
| **Health Advisor - A**<br>Support for healthy and at-risk individuals to help them stay healthy<br>• Health Assessments<br>• Health and Wellness Coaching<br>• Cigna Well Informed Program<br>• Preference Sensitive Care<br>• Educate and Refer | Included |
| **eVisits** | Included |

**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.

## 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.

## Dollars & Sense

**DOLLARS & SENSE:**Easy ways to decrease your out-of-pocket health care expenses.
**In-network care**
Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
**Urgent care**
**(Average urgent care center cost $131 / Average hospital ER cost $1,523)**
Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.
**Convenience care or retail clinics**
**(Average convenience care clinic cost $61 / Average hospital ER cost $1,523)**
Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are

## Dollars & Sense

located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

**Laboratory and pathology tests**

**(Average LabCorp/Quest cost $9 / Average other lab cost $24 / Average outpatient hospital lab cost $48)**

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

**Radiology services (MRI or CT scan)**

**(Average independent radiology facility cost $591 / Average outpatient hospital cost $1,198)**

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

**Colonoscopy, endoscopy or arthroscopy**

**(Average freestanding surgery center cost $1,438 / Average outpatient hospital cost $2,821)**

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

**Cigna Home Delivery Pharmacy**

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

## Exclusions

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

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

## Exclusions

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, 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 "Home Health Services" or "Breast Reconstruction and Breast

## Exclusions

Prostheses" sections of this plan.

- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- massage therapy.

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

# ATTACHMENT 2: CIGNA POS MEDICAL AND RX SCHEDULE OF BENEFITS

# CLIENT SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**
**For - City of Naples**
**Open Access Plus Plan**

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Coinsurance** | Plan pays 80% coinsurance | Plan pays 50% coinsurance |
| **Maximum Reimbursable Charge**<br><br>Out-of-network services are subject to a Contract 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 (80%) 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. | Not Applicable | 80th Percentile |
| **Contract Year Deductible**<br>• The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.<br>• 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.<br>• This plan includes a combined Medical/Pharmacy plan deductible.<br>• Home delivery pharmacy costs contribute to the combined medical/pharmacy deductible. | Individual: $600<br>Individual +1: $1,200<br>Employee and Family: $1,600 | Individual: $1,500<br>Individual + 1:$2,500<br>Employee and Family: $3,500 |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Contract Year Out-of-Pocket Maximum**<br>• The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.<br>• Deductibles do not contribute towards the out-of-pocket maximum.<br>• Mental health and substance abuse covered expenses contribute towards your out-of-pocket maximum.<br>• 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. | Individual: $2,000<br>Individual + 1: $3,000<br>Employee and Family: $4,000 | Individual: $6,000<br>Individual + 1: $9,000<br>Employee and Family: $12,000 |
| **Pre-Existing Condition Limitation (PCL)** | Not applicable to anyone under 19 years old<br><br>PCL applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details. | |
| **Pre-certification - Continued Stay Review - PHS+ Inpatient** - required for all inpatient admissions | Coordinated by your physician | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.<br>• $250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.<br>• Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.<br>• Benefits are denied for any additional days not certified by Cigna Healthcare. |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Pre-certification - Continued Stay Review - PHS+ Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing | Coordinated by your physician | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.<br>• $250 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.<br>• Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified. |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Physician Services** | | |
| **Primary Care Physician (PCP) Office Visit** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Specialty Care Physician Office Visit** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Surgery Performed in Physician's Office** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Allergy Treatment/Injections** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Allergy Serum**<br>Dispensed by the physician in the office | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Preventive Care** | | |
| **Routine Preventive Care - All Ages**<br>• Includes well-baby, well-child, well-woman and adult preventive care<br>• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. | Plan pays 100%, no plan deductible | Children age 0-15 :<br>Plan pays 50% coinsurance and plan deductible is waived<br><br>Adults and children age 16 and older:<br>Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Preventive Care** | | |
| **Immunizations** | Plan pays 100%, no plan deductible | Children age 0-15 :<br>Plan pays 50% coinsurance and plan deductible is waived<br><br>Adults and children age 16 and older:<br>Plan pays 50% coinsurance after plan deductible is met |
| **Mammogram, PAP, PSA Tests**<br>• Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | Plan pays 100%, no plan deductible | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Inpatient** | | |
| **Inpatient Hospital Facility**<br><br>**Semi-Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**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 | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **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. | |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient** | | |
| **Outpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Short-Term Rehabilitation**<br>Per Contract Year Maximums:<br>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 60 days<br>• Cardiac Rehabilitation - 36 days<br><br>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care**<br>(includes outpatient private duty nursing days when approved as medically necessary)<br>• 60 days maximum per Contract Year<br>• 16 hour maximum per day | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility**<br>• 60 days maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Durable Medical Equipment**<br>• Unlimited maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.<br>• Includes related supplies | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met |
| **External Prosthetic Appliances (EPA)**<br>• Unlimited maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Routine Foot Disorders** | Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. | Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. |
| **Oral Surgery - Impacted Wisdom Teeth Inpatient Facility** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Other Health Care Facilities/Services** | | |
| **Rhinoplasty**<br>• Unlimited maximum per Contract Year | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Wigs** Maximum 2 per lifetime<br>• Subject to Medical Necessity | Plan pays 0% coinsurance plan deductible is waived | Plan pays 50% coinsurance after plan deductible is met |

**Place of Service - You pay based on where you receive services.**

| Benefit | Physician's Office | | Outpatient Facility | | Emergency Room/ Urgent Care Facility | | Independent Lab | | Inpatient Hospital | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 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 |
| **X-ray** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| **Lab** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 70% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| **Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | | Not Applicable | Not Applicable | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

**Place of Service - You pay based on where you receive services.**

| Benefit | Physician's Office | | Emergency Room | | Outpatient Professional Services (Radiologist, Pathologist, ER Physician) | | *Ambulance | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Emergency Care** | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician's Office** | | **Emergency Room** | | **Outpatient Professional Services (Radiologist, Pathologist, ER Physician)** | | ***Ambulance** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| * - Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician's Office** | | **Urgent Care Facility** | | **Outpatient Professional Services** | | ***Ambulance** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Urgent Care** | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | | Plan pays 80% coinsurance after plan deductible is met | |
| * - Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Initial Visit to Confirm Pregnancy** | | **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** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services. | | | | |
|---|---|---|---|---|
| **Benefit** | **Inpatient Hospital and Other Health Care Facilities** | | **Outpatient Services** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Hospice (provided as part of Hospice Care Program)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| **Bereavement Counseling (Services provided as part of Hospice Care Program)** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **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) | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician' s Services - Office Visit** | | **Inpatient Hospital Facility** | | **Outpatient Facility Services** | | **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** |
| **Family Planning - Men's Services** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Includes surgical services, such as vasectomy (excludes reversals). | | | | | | | | | | |
| **Family Planning - Women's Services** | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met | Plan pays 100% | Plan pays 50% coinsurance after plan deductible is met |
| Includes surgical services, such as tubal ligation (excludes reversals). | | | | | | | | | | |
| Contraceptive devices as ordered or prescribed by a physician. | | | | | | | | | | |
| **Infertility** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |
| **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. | | | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | |
|---|---|---|---|---|---|---|
| **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** | Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | Not covered | Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | Not covered |
| Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician' s Services - Office Visit** | | **Inpatient Hospital Facility** | | **Outpatient Facility Services** | | **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** |
| **Dental Care** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. | | | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **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** - case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |
| Non-Surgical: Unlimited maximum per lifetime | | | | | | | | | | |

| Place of Service - You pay based on where you receive services. | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit** | **Physician' s Services - Office Visit** | | **Inpatient Hospital Facility** | | **Outpatient Facility Services** | | **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** |
| **Bariatric Surgery** | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered | Not covered |

| Place of Service - You pay based on where you receive services. | | | | | | |
|---|---|---|---|---|---|---|
| **Benefit** | **Inpatient** | | **Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health)** | | **Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health)** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Mental Health** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

- Unlimited maximum per contract year
- Mental Health services are paid at 100% after you reach your out-of-pocket maximum

| Place of Service - You pay based on where you receive services. | | | | | | |
|---|---|---|---|---|---|---|
| **Benefit** | **Inpatient** | | **Outpatient - Physician's Office (includes individual and intensive outpatient substance abuse)** | | **Outpatient Facility (includes individual and intensive outpatient substance abuse)** | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Substance Abuse** | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 50% coinsurance after plan deductible is met |

**Note:** Detox is covered under medical

- Unlimited maximum per contract year
- Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum

## Mental Health and substance abuse services

**MH/SA Service Specific Administration**

Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- Partial Hospitalization: The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- Standard for Residential Treatment: Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management.
- Intensive Outpatient Program (IOP): Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.

**Mental Health/Substance Abuse Utilization Review, Case Management and Programs**

Cigna Behavioral Advantage - 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: Strength and Resilience, Quit Today and Healthy Steps to Weight Loss.
- Narcotic Therapy Management

| Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| **Cigna Pharmacy three-tier coinsurance plan**<br>• Patient is responsible for the applicable coinsurance based upon the tier of the dispensed medication.<br>• Self Administered injectable drugs - excludes infertility drugs<br>• Oral Contraceptives included<br>• Includes Oral Contraceptives - with specific products covered 100%<br>• Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included | **Retail** - 30 day supply<br>Generic: You pay 30%<br>Preferred Brand: You pay 40%<br>Non-Preferred Brand: You pay 50%<br><br>**Home delivery** - 90 day supply<br>Generic: You pay 30%<br>Preferred Brand: You pay 40%<br>Non-Preferred Brand: You pay 50% | **Retail**<br>You pay 50%<br>Plan pays 50%<br><br>**Home Delivery**<br>You pay 50%<br>Plan pays 50% |

| Pharmacy | In-Network | Out-of-Network |
|---|---|---|

**Pharmacy Clinical Management and Prior Authorization**

- Your plan is subject to certain clinical edits and prior authorization requirements
- Refill-too-soon and plan exclusion edits are always included
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications

**Specialty Pharmacy Management:**

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
- Medication Access Option
  - Retail and/or Home Delivery

## Additional Information

**Prescription Drug List:**

- Cigna Standard Prescription Drug List

## Health and Wellness Programs

**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.

## 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.

## Dollars & Sense

**DOLLARS & SENSE:**Easy ways to decrease your out-of-pocket health care expenses.
**In-network care**
Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
**Urgent care**
**(Average urgent care center cost $131 / Average hospital ER cost $1,523)**
Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER

## Dollars & Sense

can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.

**Convenience care or retail clinics**

**(Average convenience care clinic cost $61 / Average hospital ER cost $1,523)**

Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

**Laboratory and pathology tests**

**(Average LabCorp/Quest cost $9 / Average other lab cost $24 / Average outpatient hospital lab cost $48)**

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

**Radiology services (MRI or CT scan)**

**(Average independent radiology facility cost $591 / Average outpatient hospital cost $1,198)**

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

**Colonoscopy, endoscopy or arthroscopy**

**(Average freestanding surgery center cost $1,438 / Average outpatient hospital cost $2,821)**

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

**Cigna Home Delivery Pharmacy**

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

## Exclusions

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

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- 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.

## Exclusions

- for or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, 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.

## Exclusions

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.

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

## ATTACHMENT 3: CIGNA CDHP MEDICAL AND RX SBC

# City of Naples: Choice Fund Open Access Plus HRA

**Coverage Period: 10/01/2013 - 09/30/2014**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-Cigna24

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers **$1,500** person / **$2,250** person +1 / **$3,000** family<br>For out-of-network providers **$3,000** person / **$4,500** person + 1/ **$6,000** family<br>Deductible per person applies when the employee is the only person covered under the plan.<br>Does not apply to in-network preventive care<br>Amount your employer contributes to your account: Up to **$750** person / **$1,250** person + spouse or child / **$1,500** family. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For in-network providers **$3,000** person / **$4,500** person + 1/ **$6,000** family / For out-of-network providers **$6,000** person / **$9,000** person + 1/ **$12,000** family.<br>Out-of-pocket limit for person applies when the employee is the only person covered under the plan. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24** | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Specialist visit | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Other practitioner office visit | 20% co-insurance for chiropractor | 50% co-insurance | Coverage for Chiropractic care and Rehabilitation services is limited to 60 days annual max. |
| | Preventive care/screening/ immunization -Out-of-network deductibles do not apply to preventive care for children through age 15 -Out-of-network deductibles do not apply to immunizations for children through age 15 | No charge | 50% co-insurance | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-insurance for x-ray 30% co-insurance for lab | 50% co-insurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 50% co-insurance | ----------none---------- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.myCigna.com | Generic drugs | 30% co-insurance/prescription (retail), 30% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Preferred brand drugs | 40% co-insurance/prescription (retail), 40% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Non-preferred brand drugs | 50% co-insurance/prescription (retail), 50% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| **If you need immediate medical attention** | Emergency room services | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Urgent care | 20% co-insurance | 20% co-insurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Substance use disorder outpatient services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Substance use disorder inpatient services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| **If you are pregnant** | Prenatal and postnatal care | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Delivery and all inpatient services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you need help recovering or have other special health needs** | Home health care | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. Coverage is limited to 60 days annual max. Maximums cross-accumulate. |
| | Rehabilitation services | 20% co-insurance | 50% co-insurance | 50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services |
| | Habilitation services | Not Covered | Not Covered | ----------none---------- |
| | Skilled nursing care | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. Coverage is limited to 60 days annual max. |
| | Durable medical equipment | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| | Hospice services | 20% co-insurance | 50% co-insurance | 50% penalty for no precertification. |
| **If your child needs dental or eye care** | Eye Exam | Not Covered | Not Covered | ----------none---------- |
| | Glasses | Not Covered | Not Covered | ----------none---------- |
| | Dental check-up | Not Covered | Not Covered | ----------none---------- |

## Excluded Services & Other Covered Services

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------*

# Coverage Examples

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples. Please consider any contributions you may receive in an HRA, HSA or FSA.

**Note:** These numbers assume enrollment in individual-only coverage.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,820
- **Patient pays:** $2,720

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine Obstetric Care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductible | $1,500 |
| Co-pays | $0 |
| Co-insurance | $1,190 |
| Limits or exclusions | $30 |
| **Total** | **$2,720** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,600
- **Patient pays:** $2,800

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical equipment and supplies | $1,300 |
| Office visits & procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductible | $1,500 |
| Co-pays | $0 |
| Co-insurance | $1,020 |
| Limits or exclusions | $280 |
| **Total** | **$2,800** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Plan ID:** 20741
**Plan Name:**Cigna Choice Fund Health Reimbursement Account Ope

# ATTACHMENT 4: CIGNA POS MEDICAL AND RX SBC

# City of Naples: Open Access Plus

**Coverage Period: 10/01/2013 - 09/30/2014**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-Cigna24

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers **$600** person / **$1,200** person + 1/ **$1,600** family<br>For out-of-network providers **$1,500** person / **$2,500** person + 1/ **$3,500** family<br>Does not apply to in-network preventive care | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For in-network providers **$2,000** person / **$3,000** person + 1/ **$4,000** family / For out-of-network providers **$6,000** person / **$9,000** person + 1/ **$12,000** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premium, balance-billed charges, medical co-payments/deductibles, penalties for no pre-authorization, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24** | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Specialist visit | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Other practitioner office visit | 20% co-insurance for chiropractor | 50% co-insurance | Coverage for Chiropractic and Rehabilitation services is limited to 60 days annual max. |
| | Preventive care/screening/immunization<br>-Out-of-network deductibles do not apply to preventive care for children through age 15<br>-Out-of-network deductibles do not apply to immunizations for children through age 15 | No charge | 50% co-insurance | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-insurance for x-ray<br>30% co-insurance for lab | 50% co-insurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 50% co-insurance | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.myCigna.com | Generic drugs | 30% co-insurance/prescription (retail), 30% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Preferred brand drugs | 40% co-insurance/prescription (retail), 40% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Non-preferred brand drugs | 50% co-insurance/prescription (retail), 50% co-insurance/prescription (home delivery) | 50% co-insurance | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| **If you need immediate medical attention** | Emergency room services | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Urgent care | 20% co-insurance | 20% co-insurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Substance use disorder outpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Substance use disorder inpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you are pregnant** | Prenatal and postnatal care | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Delivery and all inpatient services | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| **If you need help recovering or have other special health needs** | Home health care | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. Coverage is limited to 60 days annual max. Maximums cross-accumulate. |
| | Rehabilitation services | 20% co-insurance | 50% co-insurance | $250 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services |
| | Habilitation services | Not Covered | Not Covered | ----------none---------- |
| | Skilled nursing care | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. Coverage is limited to 60 days annual max. |
| | Durable medical equipment | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| | Hospice services | 20% co-insurance | 50% co-insurance | $250 penalty for no precertification. |
| **If your child needs dental or eye care** | Eye Exam | Not Covered | Not Covered | ----------none---------- |
| | Glasses | Not Covered | Not Covered | ----------none---------- |
| | Dental check-up | Not Covered | Not Covered | ----------none---------- |

## Excluded Services & Other Covered Services

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Acupuncture<br>• Bariatric surgery<br>• Cosmetic surgery<br>• Dental care (Adult)<br>• Dental care (Children)<br>• Eye care (Children) | • Habilitation services<br>• Hearing aids<br>• Infertility treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing | • Routine eye care (Adult)<br>• Routine foot care<br>• Weight loss programs |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | |
|---|---|---|
| • Chiropractic care | | |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------*

# Coverage Examples

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,540
- **Patient pays:** $2,000

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine Obstetric Care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductible | $600 |
| Co-pays | $0 |
| Co-insurance | $1,370 |
| Limits or exclusions | $30 |
| **Total** | **$2,000** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,280
- **Patient pays:** $2,120

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical equipment and supplies | $1,300 |
| Office visits & procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductible | $600 |
| Co-pays | $0 |
| Co-insurance | $1,240 |
| Limits or exclusions | $280 |
| **Total** | **$2,120** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

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## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Plan ID:** 20739
**Plan Name:**Open Access Plus Coinsurance