

## SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.**  
**For - Frederick County Government**  
**Open Access Plus Plan**  
**Effective - 01/01/2020**

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

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

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Coinsurance</b> <ul style="list-style-type: none"> <li>Coinsurance values can vary for specific benefits</li> </ul>	Your plan pays 90%	Your plan pays 80%
<b>Maximum Reimbursable Charge</b>	Not Applicable	80th Percentile
<b>Calendar Year Deductible</b> <ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts towards both your in-network and out-of-network deductibles.</li> <li>Copays always apply before plan deductible and coinsurance.</li> <li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>	Individual: None Family: None	Individual: \$300 Family: \$600
<b>Calendar Year Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li> <li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>	Individual: \$1,250 Family: \$2,500	Individual: \$2,300 Family: \$4,600

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Benefit	In-Network	Out-of-Network
<b>Physician Services - Office Visits</b>		
<b>Physician Office Visit – Primary Care Physician (PCP)</b>	\$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Physician Office Visit – Specialist</b>	\$30 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
<b>Surgery Performed in Physician’s Office - PCP</b>	\$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Surgery Performed in Physician's Office – Specialist</b>	\$30 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Allergy Treatment/Injections Performed in Physician's Office PCP</b>	\$20 copay, then your plan pays 100% or actual charge (if less)	After the plan deductible is met, your plan pays 80%
<b>Allergy Treatment/Injections Performed in Specialist Office</b>	\$30 copay, then your plan pays 100% or actual charge (if less)	After the plan deductible is met, your plan pays 80%
<b>Allergy Serum - PCP</b>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Allergy Serum - Specialist</b>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<ul style="list-style-type: none"> <li>Dispensed by the physician in the office</li> </ul>		
<b>Cigna Telehealth Connection Services</b>	\$20 copay, then your plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li> <li>Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.</li> </ul>		

Benefit	In-Network	Out-of-Network
<b>Preventive Care</b>		
<b>Preventive Care</b> Birth through age 16  Ages 17 and older  <ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li> </ul>	Plan pays 100%  Plan pays 100%	PCP: Plan pays 80% Specialist: Plan pays 80% PCP: After the plan deductible is met, your plan pays 80% Specialist: After the plan deductible is met, your plan pays 80%
<b>Immunizations</b> Birth through age 16  Ages 17 and older	Plan pays 100%  Plan pays 100%	PCP: Your plan pays 80% Specialist: Your plan pays 80% PCP: After the plan deductible is met, your plan pays 80% Specialist: After the plan deductible is met, your plan pays 80%
<b>Mammogram, PAP, and PSA Tests</b>  <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	Plan pays 100%	Plan pays based on place of service.
<b>Inpatient</b>		
<b>Inpatient Hospital Facility Services</b>	\$300 per admit copay, then your plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%
<b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Outpatient</b>		
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible.</li> </ul>	\$25 per facility visit copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%

Benefit	In-Network	Out-of-Network
<b>Short-Term Rehabilitation - PCP</b>	\$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Short-Term Rehabilitation - Specialist</b>	\$30 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<p>Calendar Year Maximums:</p> <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Chiropractic Care and Cardiac Rehabilitation – 90 days</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul> <p><b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</p>		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>60 days maximum per Calendar Year (The limit is not applicable to mental health and substance use disorder conditions.)</li> <li>16 hour maximum per day</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> <ul style="list-style-type: none"> <li>60 days maximum per Calendar Year</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> <li>External prosthetic appliances meant to replace, in whole or in part, an arm, a leg or an eye: benefit levels will be the same as the benefit levels for primary care benefits.</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Routine Foot Disorders</b> Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
<b>Acupuncture Performed in Physician's Office - PCP</b>	\$20 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Acupuncture Performed in Physician's Office - Specialist</b> <ul style="list-style-type: none"> <li>Unlimited days maximum per Calendar Year</li> </ul>	\$30 copay, then your plan pays 100%	After the plan deductible is met, your plan pays 80%

Benefit	In-Network	Out-of-Network
<b>Hearing Aid</b> <ul style="list-style-type: none"> <li>Unlimited devices per 36 months</li> <li>Includes testing and fitting of hearing aid devices at Physician Office Visit cost share.</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%
<b>Wigs</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 90%	Your plan pays 90%
<b>Medical Specialty Drugs</b>		
<b>Inpatient</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.</li> </ul>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.</li> </ul>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Physician's Office</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.</li> </ul>	Your plan pays 100%	After the plan deductible is met, your plan pays 80%
<b>Home</b> <ul style="list-style-type: none"> <li>This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.</li> </ul>	Your plan pays 90%	After the plan deductible is met, your plan pays 80%

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

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

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Laboratory</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 80% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 90%	Plan pays 80% ^
<b>Radiology</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 90%	Plan pays 80% ^

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

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

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Advanced Radiology Imaging</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 90%	Covered same as plan's Outpatient Facility Services

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

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

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Emergency Care</b>	\$150 per visit (copay waived if admitted), then your plan pays 100%		Plan pays 100%		Plan pays 90%	
<b>Urgent Care</b>	\$30 per visit, your plan pays 100%		Plan pays 100%		Not Applicable*	

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

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Hospice</b>	Plan pays 90%	Plan pays 80% ^	Plan pays 90%	Plan pays 80% ^
<b>Bereavement Counseling</b>	Plan pays 90%	Plan pays 80% ^	Plan pays 90%	Plan pays 80% ^

Note: Services provided as part of Hospice Care Program

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Maternity</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 90%	Plan pays 80% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Abortion</b> (Elective and non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	\$300 per admit copay, then your plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	\$25 per facility visit copay, then your plan pays 100%	Plan pays 80% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
<b>Family Planning - Men's Services</b>	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Plan pays 100%	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as vasectomy (excludes reversals)										
<b>Family Planning - Women's Services</b>	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Plan pays 100%	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
<b>Infertility</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	\$300 per admit copay, then your plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	\$25 per facility visit copay, then your plan pays 100%	Plan pays 80% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, GIFT, ZIFT, etc. Also includes outpatient in-vitro fertilization, up to 3 attempts per live birth. Unlimited maximum per lifetime										

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Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>TMJ, Surgical and Non-Surgical</b>	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	\$300 per admit copay, then your plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	\$25 per facility visit copay, then your plan pays 100%	Plan pays 80% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services

Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Cigna LifeSOURCE Transplant Network® Facility In-Network	Non-Lifeforce Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network® Facility In-Network	Non-Lifeforce Facility In-Network	Out-of-Network
<b>Organ Transplants</b>	\$300 per admission copay	\$300 per admit copay, then your plan pays 100%	\$600 per admit deductible and plan deductible, then your plan pays 80%	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services

- Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility: Unlimited
- Out-of-Network Transplant Maximum - \$75,000 annual maximum

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Mental Health</b>	\$300 per admission copay	\$600 per admission deductible, then plan pays 80% ^	\$30 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
<b>Substance Use Disorder</b>	\$300 per admission copay	\$600 per admission deductible, then plan pays 80% ^	\$30 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

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

**Notes:**

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization.
- Detox is covered under medical.

## Mental Health and Substance Use Disorder Services

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

### Pharmacy

### In-Network

### Out-of-Network

### Cost Share and Supply

#### Cigna Pharmacy Cost Share

- Retail – up to 90-day supply
- Home Delivery – up to 90-day supply
- Oral specialty medications are covered at Non-Specialty cost share

#### Retail (per 30-day supply):

Generic: You pay \$10  
 Preferred Brand: You pay \$30  
 Non-Preferred Brand: You pay \$50  
 Specialty: You pay \$75

#### Retail and Home Delivery (per 90-day supply):

Generic: You pay \$20  
 Preferred Brand: You pay \$60  
 Non-Preferred Brand: You pay \$100  
 Specialty: You pay \$150

#### Retail:

You pay 20%  
 Your plan pays 80%

#### Home Delivery:

Same as Retail Out-of-Network

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- You can choose to fill your medications in a 30- or 90-day supply at any network pharmacy.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

#### For Delaware and Vermont residents:

For prescription drug plans that include a mail order drug plan (home delivery), the copayment for a 90-day supply at retail or mail order pharmacies will be equal to three times the copayment for a 30-day supply. The copayment for a 90-day supply when obtained from either a retail or mail order drug pharmacy will be equal. The mail order drug plan coinsurance level for a 90-day supply will be the same as the retail coinsurance level. Each prescription order or refill will be limited to up to a consecutive 90-day supply at a mail order or retail participating pharmacy, unless limited by the drug manufacturer's packaging or other applicable law.

## Drugs Covered

### Prescription Drug List:

Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.
- Prescription smoking cessation drugs are covered.

## Pharmacy Program Information

### Pharmacy Clinical Management

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

- Prior authorization requirements.
- Quantity over time edits and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

## Additional Information

### Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

### Health Advisor - A

Support for healthy and at-risk individuals to help them stay healthy

- Health Assessments
- Health and Wellness Coaching
- Gaps in Care Coaching
- Treatment Decision Support
- Educate and Refer

Included

## Additional Information

### Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

\$150 (1st trimester) / \$75 (2nd trimester) - Option 3

### Maximum Reimbursable Charge

Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. 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. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

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

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

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

### One Guide

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

## Additional Information

### Pre-Certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

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

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

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

### Your Health First - 300

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

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

Holistic health support for the following chronic health conditions:

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

## Definitions

**Coinsurance** - After you've reached your out-of-network deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

**Place of service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

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

**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

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

## Exclusions

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

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

- Care required by state or federal law to be supplied by a public school system or school district. Behavioral care services provided by a Participating Provider will not be denied solely because it was rendered at a public school or through a school based health center.
- 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.
- 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. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider, that exceed those agreed upon, if the provider has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - o 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;
  - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - o The subject of an ongoing phase I, II, III or IV clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
  - o In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
- The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following:
  - o The national institutes of health (NIH);
  - o An NIH cooperative group or an NIH center;

## Exclusions

- o The FDA in the form of an investigational new drug application;
  - o The federal department of veterans affairs; or
  - o An institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.
- Cosmetic surgery and therapies, except as specified in the "Breast Reconstruction and Breast Prostheses" section of this plan. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
  - The following services are excluded from coverage regardless of clinical indications: 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 teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth). Charges for inpatient and outpatient services for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment, involved with the management of the birth defect known as cleft lip or cleft palate, or both, are covered. Charges for diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care Provider rendering the service, the procedure is Medically Necessary to treat a condition caused by congenital deformity, disease or Injury, are covered.
  - For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
  - Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
  - Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
  - Any claim, bill or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a referral prohibited by the Maryland Health Occupations Article.
  - 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), anorgasm, 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. However, this exclusion does not apply to charges for inpatient hospitalization services and home visits, with respect to a newborn child, as provided in the "Covered Expenses" section.
  - Non-medical counseling or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and drive safety courses.
  - Consumable medical supplies other than ostomy supplies and urinary catheters, or as otherwise covered items. 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 beyond the rates approved by the Health Services Cost Review Commission 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

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## Exclusions

meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- Artificial aids, specifically: corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures, except as may otherwise be provided for under "Covered Expenses."
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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 (except for medical foods and modified food products and amino acid-based elemental formula as provided for in the "Covered Expenses" section) and health and beauty aids.
- All nutritional supplements and formulae except for those described in the "Nutritional Products" provision of the "Covered Expenses" section.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, email, and internet consultations except as provided for under the "Telemedicine" provision of the "Covered Expenses" section.
- Massage therapy.

### These are only the highlights

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

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

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# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file

a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.368.1019, 800.537.7697 (TDD)  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LỜI Ỗ: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけません。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).