Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $3,500 Family: $7,000	Individual: $3,500 Family: $7,000

The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.
Plan deductible contributes towards your out-of-pocket maximum.
All benefit copays/deductibles contribute towards your out-of-pocket maximum.
Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use

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Open Access Plus - Basic

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Urgent Care Facility Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Ambulance	Plan pays 80% ^	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities Annual Limit: 150 days	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services		
Outpatient Therapy and Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: Cardiac Rehabilitation - 36 days		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Lifetime Maximum: Unlimited		
Other Health Care Facilities/Services		
Home Health Care Annual Limit: Unlimited 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 80% ^	Plan pays 60% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	Plan pays 100%	Plan pays 80% ^
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Plan pays 80% ^
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Plan pays 80% ^
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Plan pays 80% ^ up to the following transplant maximums: Bone Marrow - $130,000 Heart - $150,000 Heart/Lung - $185,000 Kidney - $80,000 Kidney/Pancreas - $80,000 Liver - $230,000 Lung - $185,000 Pancreas - $50,000
Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment Annual Limit: Unlimited	Plan pays 100%	Plan pays 60% ^
Diabetic Pumps and Supplies Annual Limit: Unlimited	Plan pays 100%	Plan pays 60% ^
Breast Feeding Equipment and Supplies Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies	Plan pays 100%	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health		

Pharmacy	In-Network	Out-of-Network

Pharmacy Program Information

Pharmacy Clinical Management: Essential

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
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.

Additional Information

Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) 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 will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service 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 data in the database for similar services may be used. 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 as required by applicable state or federal law 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 as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any 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**

Additional Information

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.
The lesser of 50% or $500 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.
The lesser of 50% or $500 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

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

Holistic health support for the following chronic health conditions:
Heart Disease
Coronary Artery Disease
Angina
Congestive Heart Failure
Acute Myocardial Infarction
Peripheral Arterial Disease
Asthma
Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
Diabetes Type 1
Diabetes Type 2
Metabolic Syndrome/Weight Complications
Osteoarthritiission

Exclusions

supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- 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;
- 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.
- In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

Exclusions

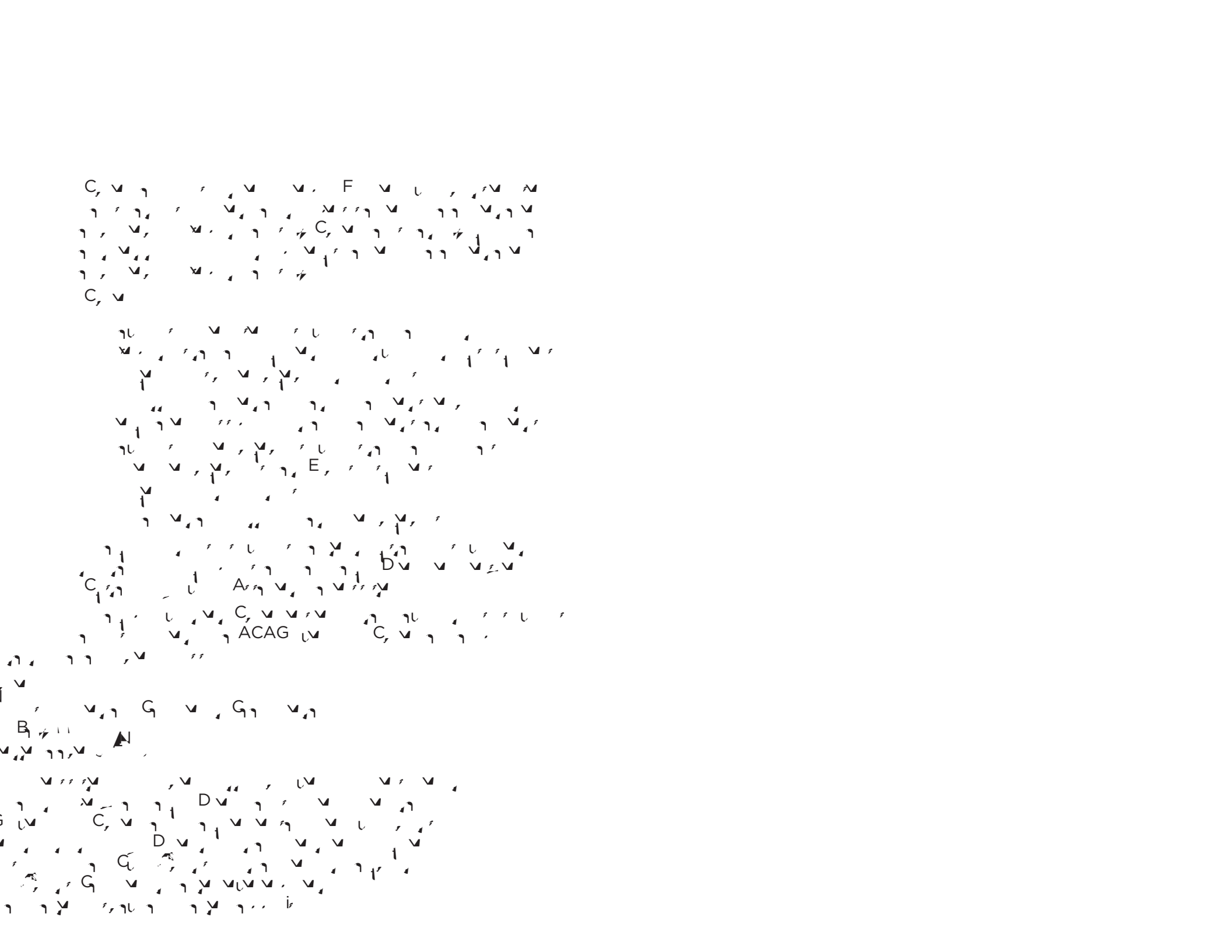
cataract surgery.

Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Acupuncture.

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.

Products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products



Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of

Spanish – ATENC

sin cargo, a su

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

的現有客戶，請致電您的 ID

Vie

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:

무료로 이용하실 수 있습니다. 현재 Cigna

카드 뒷면에 있는

1.800

Tagalog – PAU

tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID

O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – В

услуги перево

позвоните по номеру, указанному на обратной стороне

вашей идентификационной карточки участника плана.

Если

планов,

Arabic –

الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب

(711 اتصل ب :TTY) 1.800.244.6224

French Creole – ATANSYON:

Portuguese – ATENÇÃO:

número que se encontra no verso do seu cartão de identificação.

Polish – UWAGA:

językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby

Japanese – 注意事項：

Italian – ATTENZIONE:

1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG:

Cigna-Kunde sind, rufen Sie bitte

(TTY: Wählen Sie 711).

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