CLIENT SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Chicago Transit Authority
Open Access Plus Plan 2

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Plan pays 90% coinsurance	Plan pays 70% coinsurance
Maximum Reimbursable Charge Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a 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%
Calendar Year Deductible • Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles. • 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.	Individual: $350 Family: $700	Individual: $1,000 Family: $2,000

Plan Highlights	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum • Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums. • Plan deductibles contribute towards your out-of-pocket maximum. • All copays and benefit deductibles contribute towards your out-of-pocket maximum. • Mental health and substance abuse covered expenses contribute towards your out-of-pocket maximum. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. • Prescription drug expenses/copays/coinsurance do not contribute towards your out-of-pocket maximum.	Individual: $1,350 Family: $2,700	Individual: $3,000 Family: $6,000
Pre-Existing Condition Limitation (PCL)	Not Applicable	Not Applicable
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. • 20% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission. • Benefits are denied for any admission reviewed by Cigna Healthcare and not certified. • Benefits are denied for any additional days not certified by Cigna Healthcare.
Benefit	**In-Network**	**Out-of-Network**
Physician Services		
Primary Care Physician (PCP) Office Visit	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Physician Services		
Specialty Care Physician Office Visit	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met
Surgery Performed in Physician's Office	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met
Allergy Treatment/Injections	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met
Allergy Serum Dispensed by the physician in the office	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Preventive Care		
Routine Preventive Care - All Ages • Includes well-baby, well-child, well-woman and adult preventive care • 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	Not covered
Immunizations - All Ages	Plan pays 100%, no plan deductible	Not covered
Mammogram, PAP, PSA Tests • Coverage includes the associated Preventive Outpatient Professional Services. • Associated wellness exam is covered in-network only. • 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 70% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Inpatient		
Inpatient Hospital Facility **Semi-Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Inpatient Hospital Physician's Visit/Consultation	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Short-Term Rehabilitation Per Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 60 days • Cardiac Rehabilitation - 36 days • Chiropractic Care - 36 days • Autism Treatments/Therapies - Unlimited maximum (Per Illinois Mandate) 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 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) • 40 days maximum per Calendar Year • 16 hour maximum per day	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Calendar Year	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Durable Medical Equipment • Unlimited maximum per Calendar Year	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
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%	Not covered
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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 - Facility	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Smoking Cessation Treatment • Out-of-network physician's office visits are subject to the applicable per visit deductible	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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
Lab and X-ray	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	**Emergency Room:** Plan pays 100% after plan deductible is met **Urgent Care:** Plan pays 90% coinsurance after plan deductible is met		Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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 90% coinsurance after plan deductible is met	$25 per visit deductible th en Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	**Emergency Room:** Plan pays 100% after plan deductible is met **Urgent Care:** Plan pays 90% 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 90% coinsurance after plan deductible is met		$100 per visit (copay waived if admitted) and plan deductible; then Plan pays 100%		Plan pays 100% after plan deductible is met		Plan pays 90% 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 90% coinsurance after plan deductible is met		Plan pays 90% coinsurance after plan deductible is met		Plan pays 90% coinsurance after plan deductible is met		Plan pays 90% 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 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

- Coverage applies to employees, spouses and dependent children.

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 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Bereavement Counseling (Services provided as part of Hospice Care Program)	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met
Includes surgical services, such as vasectomy (excludes reversals).										
Family Planning - Women's Services	Plan pays 100%	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 100%	Plan pays 70% coinsurance after plan deductible is met	Plan pays 100%	Plan pays 70% coinsurance after plan deductible is met	Plan pays 100%	Plan pays 70% coinsurance after plan deductible is met	Plan pays 100%	Plan pays 70% 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 90% coinsurance after plan deductible is met	Not covered	Plan pays 100%	Plan pays 90% coinsurance after plan deductible is met	Not covered

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 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% 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	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	**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	Plan pays 90% coinsurance after plan deductible is met	Not covered	Plan pays 90% coinsurance after plan deductible is met	Not covered	Plan pays 90% coinsurance after plan deductible is met	Not covered	Plan pays 90% coinsurance after plan deductible is met	Not covered	Plan pays 90% coinsurance after plan deductible is met	Not covered

Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered only at approved centers.
The following are excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.
- weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision

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 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met

- Unlimited maximum per calendar 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 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	$25 per visit deductible then Plan pays 70% coinsurance after plan deductible is met	Plan pays 90% coinsurance after plan deductible is met	Plan pays 70% coinsurance after plan deductible is met

Note: Detox is covered under medical

- Unlimited maximum per calendar 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: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy

Pharmacy benefits not provided by Cigna

Health and Wellness Programs

Your Health First - 200

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

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

Holistic health support for the following chronic health conditions:

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

Health and Wellness Programs

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Cigna Well Informed Program • Preference Sensitive Care • Educate and Refer	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 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.

Dollars & Sense

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.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document.
  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the

Exclusions

subject of review or approval by an Institutional Review Board for the proposed use.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: 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.
- surgical or nonsurgical treatment of TMJ disorders.
- 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.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, **except** for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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 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 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 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.

Exclusions

- 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, and weight loss 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.