Summary of Benefits

Cigna Health and Life Insurance Co.
For - University of Maine System
Choice Fund Open Access Plus HSA Plan

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

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

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

Plan Highlights

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited</td>
<td>Your plan pays 90%</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Unlimited</td>
<td>Your plan pays 70%</td>
<td></td>
</tr>
</tbody>
</table>

Maximum Reimbursable Charge

Not Applicable

200%

Calendar Year Deductible

- Individual: $1,500
- Family: $3,000
- Individual: $2,500
- Family: $5,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy deductible.

Note: Services where plan deductible applies are noted with a caret (^)
### Plan Highlights

<table>
<thead>
<tr>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual: $3,000</td>
<td>Family: $6,000</td>
<td>Individual: $6,000</td>
</tr>
<tr>
<td>Family: $6,000</td>
<td>Family: $12,000</td>
<td></td>
</tr>
</tbody>
</table>

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket maximum.

### Benefit

<table>
<thead>
<tr>
<th>Note: Services where plan deductible applies are noted with a caret (^)</th>
</tr>
</thead>
</table>

#### Physician Services

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
</tr>
</tbody>
</table>

#### Surgery Performed in Physician's Office

- Your plan pays 90% ^
- Your plan pays 70% ^

#### Allergy Treatment/Injections

- Your plan pays 90% ^
- Your plan pays 70% ^

#### Allergy Serum

- Dispensed by the physician in the office
- Your plan pays 90% ^
- Your plan pays 70% ^

#### Preventive Care

- Your plan pays 100%
- Your plan pays 70% ^

- Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.
- Includes immunizations for travel

#### Immunizations

- Your plan pays 100%
- Your plan pays 70% ^

#### Mammogram, PAP, and PSA Tests

- Your plan pays 100%
- Your plan pays 70% ^

- 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.

#### Inpatient

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
</tr>
</tbody>
</table>

#### 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

#### Inpatient Hospital Physician's Visit/Consultation

- Your plan pays 90% ^
- Your plan pays 70% ^

#### Inpatient Professional Services

- For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists
- Your plan pays 90% ^
- Your plan pays 70% ^
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation</strong></td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>Calendar YearMaximuns:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – Unlimited days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiac Rehabilitation - 36 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Massage therapy covered when part of a chiropractic visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Health Care Facilities/Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>(includes outpatient private duty nursing subject to medical necessity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unlimited days maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 16 hour maximum per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• 100 days maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Feeding Equipment and Supplies</td>
<td>Your plan pays 100%</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Includes related supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Appliances (EPA)</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Foot Disorders</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited days maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>Your plan pays 100%</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Coverage through age 18, 1 per ear every 36 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit: In-Network | Out-of-Network

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery - Impacted Wisdom Teeth</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Includes removing impacted or unerupted teeth in a non-hospital or non-rural health center setting; removing seven or more permanent teeth; Gingivectomies; Osseous surgery; setting of jaw fracture, removal of tumor or cyst; dental services needed as a result of chemotherapy; repairing or replacing dental prosthesis due to accident or injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Care Services</td>
<td>Your plan pays 100%</td>
<td>Your plan pays 100%</td>
</tr>
<tr>
<td>• 1 routine vision exam per 12 months under age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 routine vision exam per 24 months over age 18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
<tr>
<td>Advanced Radiology Imaging</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Emergency Room / Urgent Care Facility</th>
<th>Outpatient Professional Services</th>
<th>*Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital and Other Health Care Facilities</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
</tbody>
</table>

Note: Services provided as part of Hospice Care Program

Note: Services where plan deductible applies are noted with a caret (^)
### Initial Visit to Confirm Pregnancy

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Delivery - Facility (Inpatient Hospital, Birthing Center)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Covered same as plan's Inpatient Hospital benefit</td>
</tr>
<tr>
<td><strong>Global Maternity Fee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Covered same as plan's Inpatient Hospital benefit</td>
</tr>
<tr>
<td>(All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### Physician's Office

#### Abortion (Elective and non-elective procedures)

- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~

### Inpatient Facility

#### Family Planning - Men's Services

- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~

Includes surgical services, such as vasectomy

### Outpatient Facility

#### Family Planning - Women's Services

- Plan pays 100% ~
- Plan pays 70% ~
- Plan pays 100% ~
- Plan pays 70% ~
- Plan pays 100% ~
- Plan pays 70% ~
- Plan pays 100% ~
- Plan pays 70% ~
- Plan pays 100% ~
- Plan pays 70% ~

Includes surgical services, such as tubal ligation

### Inpatient Professional Services

#### Infertility

- Plan pays 90% ~
- Not covered ~
- Plan pays 90% ~
- Not covered ~
- Plan pays 90% ~
- Not covered ~
- Plan pays 90% ~
- Not covered ~
- Plan pays 90% ~
- Not covered ~

Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.

### Outpatient Professional Services

#### TMJ, Surgical and Non-Surgical

- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~
- Plan pays 90% ~
- Plan pays 70% ~

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

**Non-Surgical: Unlimited maximum per lifetime**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bariatric Surgery</strong></td>
<td>Plan pays 90% ~</td>
<td>Your plan pays 70% ~</td>
<td>Your plan pays 90% ~</td>
<td>Your plan pays 70% ~</td>
<td>Your plan pays 90% ~</td>
<td>Your plan pays 70% ~</td>
<td>Your plan pays 90% ~</td>
<td>Your plan pays 70% ~</td>
<td>Your plan pays 90% ~</td>
<td>Your plan pays 70% ~</td>
</tr>
</tbody>
</table>

**Surgeon Charges Lifetime Maximum: Unlimited**

1/1/2015

ASO / EHB State: ME

Choice Fund Health Savings Account (HSA) Open Access Plus - Choice Fund HSA - 3796846. Version# 4
Treatments of clinically severe obesity, as defined by the body mass index (BMI), are covered.

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.

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

### Organ Transplants

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital Facility</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Inpatient Professional Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifesource Facility</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 90% ^</td>
<td>Not Covered</td>
<td>Lifesource Facility In-Network</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 90% ^</td>
</tr>
<tr>
<td>Non-Lifesource Facility In-Network</td>
<td>Plan pays 90% ^</td>
<td>Not Covered</td>
<td>Lifesource Facility In-Network</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 90% ^</td>
</tr>
</tbody>
</table>

Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime

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

### Mental Health

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
<tr>
<td>Outpatient - Physician's Office</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
</tbody>
</table>

### Substance Abuse

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
<td>Plan pays 90% ^</td>
<td>Plan pays 70% ^</td>
</tr>
</tbody>
</table>

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Partial Hospitalization and Residential Treatment.
- Outpatient includes individual, intensive outpatient and group therapy.
- Note - Group Therapy applies to Mental Health only.
### 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
- Narcotic Therapy Management
- Complex Psychiatric Case Management

### Pharmacy

<table>
<thead>
<tr>
<th>Cigna Pharmacy three-tier coinsurance plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Push</td>
<td>Retail - 30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Self Administered injectable and optional injectable drugs - excludes infertility drugs</td>
<td>Preferred Brand: You pay 10% / Non-Preferred Brand: You pay 10%</td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives included</td>
<td>Oral contraceptives - with specific products covered 100%</td>
<td></td>
</tr>
<tr>
<td>Includes oral contraceptives - with specific products covered 100%</td>
<td>Lifestyle drugs included - limited to sexual dysfunction</td>
<td></td>
</tr>
<tr>
<td>Prescription smoking cessation drugs included</td>
<td>Prescription smoking cessation drugs included</td>
<td></td>
</tr>
<tr>
<td>Prescription vitamins included</td>
<td>Prescription vitamins included</td>
<td></td>
</tr>
<tr>
<td>Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges included</td>
<td>Prescription smoking cessation drugs included</td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy Program Information**

**Pharmacy Clinical Management and Prior Authorization**

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

**Prescription Drug List:**

- Cigna Standard Prescription Drug List

**Specialty Pharmacy Management:**

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

#### eVisits
Provides an online consultation service, or “eVisit,” with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay a predetermined copay or coinsurance based on their benefit plan design. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

#### 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 (200%) 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.

#### 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.

#### Pre-Certification - Continued Stay Review - PHS+ Inpatient
- **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.
  - $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 - Continued Stay Review - PHS+ Outpatient Prior Authorization
- **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.
  - $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 charges reviewed by Cigna Healthcare and not certified.

#### Pre-Existing Condition Limitation (PCL)
Does not apply. Please refer to your plan documents for specific details.
### Additional Information

<table>
<thead>
<tr>
<th>Your Health First - 200</th>
<th>Holistic health support for the following chronic health conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:</td>
<td>• Heart Disease</td>
</tr>
<tr>
<td>• Condition Management</td>
<td>• Coronary Artery Disease</td>
</tr>
<tr>
<td>• Medication adherence</td>
<td>• Angina</td>
</tr>
<tr>
<td>• Risk factor management</td>
<td>• Congestive Heart Failure</td>
</tr>
<tr>
<td>• Lifestyle issues</td>
<td>• Acute Myocardial Infarction</td>
</tr>
<tr>
<td>• Health &amp; Wellness issues</td>
<td>• Peripheral Arterial Disease</td>
</tr>
<tr>
<td>• Pre/post-admission</td>
<td>• Asthma</td>
</tr>
<tr>
<td>• Treatment decision support</td>
<td>• Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)</td>
</tr>
<tr>
<td>• Gaps in care</td>
<td>• Diabetes Type 1</td>
</tr>
</tbody>
</table>

### Definitions

- **Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
- **Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
- **Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
- **Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
- **Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.
- **Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

### Exclusions

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

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

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

- 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 subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Redundant skin surgery; 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, unless otherwise shown as covered.
- 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.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, 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.
Exclusions

- 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, elastic stockings, garter belts, corsets, dentures.
- 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.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- Massage therapy.

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