

SUMMARY OF BENEFITS



Cigna HealthCare of California, Inc. and Connecticut General Life Insurance Co.
For - City of Santee
HMO POS 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.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 100%	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable	110%
Contract Year Deductible	Individual: None Family: None	Individual: \$300 Family: \$600
<ul style="list-style-type: none"> The amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible. 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. <p>Note: Services where plan deductible applies are noted with a caret (^).</p>		
Contract Year Out-of-Pocket Maximum	Individual: \$1,500 Family: \$3,000	Individual: \$3,000 Family: \$6,000
<ul style="list-style-type: none"> Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network 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. In-Network covered expenses that count towards your out-of-pocket maximum include the member paid coinsurance and copays. Out-of-Network covered expenses that count towards your out-of-pocket maximum include the plan deductible, member paid coinsurance and benefit deductibles. Non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum. 		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
Physician Services		
Physician Office Visit <ul style="list-style-type: none"> All services including Lab & X-ray Plan pays 100% after you pay copay 	\$20 Primary Care Physician (PCP) copay or \$20 Specialist copay	Your plan pays 70% ^
Surgery Performed in Physician's Office	\$20 PCP or \$20 Specialist copay	Your plan pays 70% ^
Allergy Treatment/Injections	\$20 copay or actual charge (if less)	Your plan pays 70% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 70% ^
Cigna Telehealth Connection Services <ul style="list-style-type: none"> Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com) Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person. 	\$20 copay	Not Covered
Preventive Care		
Preventive Care <ul style="list-style-type: none"> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. 	Your plan pays 100%	Not Covered
Immunizations	Your plan pays 100%	Not Covered
Mammogram, PAP, and PSA Tests <ul style="list-style-type: none"> 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. 	Your plan pays 100%	Your plan pays 70% ^
Inpatient		
Inpatient Hospital Facility	\$150 per admission copay	\$300 per admission deductible, then your plan pays 70% ^
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 100%	Your plan pays 70% ^
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 100%	Your plan pays 70% ^
Outpatient		
Outpatient Facility Services	\$75 per facility visit copay	\$150 per facility visit deductible, then your plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 100%	Your plan pays 70% ^
Short-Term Rehabilitation Contract Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – Unlimited days in-network and Unlimited days out-of-network Note: <ul style="list-style-type: none"> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. In-Network days count towards both In-Network and Out-of-Network Maximums 	\$20 PCP or \$20 Specialist copay	Your plan pays 70% ^
Chiropractic Care Contract Year Maximums: <ul style="list-style-type: none"> Chiropractic Care - 20 days (In-network only) 	\$20 PCP or \$20 Specialist copay	Not Applicable
Cardiac Rehabilitation Contract Year Maximums: <ul style="list-style-type: none"> Cardiac Rehabilitation - Unlimited days Note: <ul style="list-style-type: none"> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. In-Network days count towards both In-Network and Out-of-Network Maximums 	\$20 Specialist copay	Your plan pays 70% ^
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> 100 days maximum in-network per Contract Year and 40 days maximum out-of-network per Contract Year. Maximums cross-accumulate. (The limit is not applicable to mental health and substance use disorder conditions.) 16 hour maximum per day 	Your plan pays 100%	Your plan pays 70% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility <ul style="list-style-type: none"> 100 days maximum in-network per Contract Year and 60 days maximum out-of-network per Contract Year. Maximums cross accumulate. 	Your plan pays 100%	Your plan pays 70% ^
Durable Medical Equipment	Your plan pays 100% Unlimited maximum per Contract Year	Not Covered

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
Breast Feeding Equipment and Supplies <ul style="list-style-type: none"> Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies 	Your plan pays 100%	Not Covered
External Prosthetic Appliances (EPA)	Your plan pays 100% Unlimited maximum per Contract Year	Not Covered
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		

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

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

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%		Plan pays 100%	Plan pays 70% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 70% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 100%	Plan pays 70% ^

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

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

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	\$50 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 100%	
Urgent Care	\$25 per visit (copay waived if admitted)		Plan pays 100%		Not Applicable	

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

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Bereavement Counseling	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered

Note: Services provided as part of Hospice Care Program

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

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	\$20 PCP or \$20 Specialist copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	\$20 PCP or \$20 Specialist copay	Plan pays 70% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

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

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)	\$20 PCP or \$20 Specialist copay	Plan pays 70% ^	\$150 per admission copay	\$300 per admission deductible, then plan pays 70% ^	\$75 per facility visit copay	\$150 per facility visit deductible, then plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Family Planning - Men's Services	\$20 PCP or \$20 Specialist copay	Plan pays 70% ^	\$150 per admission copay	\$300 per admission deductible, then plan pays 70% ^	\$75 per facility visit copay	\$150 per facility visit deductible, then plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^

Includes surgical services, such as vasectomy (excludes reversals)

Family Planning - Women's Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	\$300 per admission deductible, then plan pays 70% ^	Plan pays 100%	\$150 per facility visit deductible, then plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
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Includes surgical services, such as tubal ligation (excludes reversals)

Contraceptive devices as ordered or prescribed by a physician.

Infertility

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.

TMJ, Surgical and Non-Surgical	\$20 PCP or \$20 Specialist copay	Not Covered	\$150 per admission copay	Not Covered	\$75 per facility visit copay	Not Covered	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
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Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.

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Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

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

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Cigna LifeSOURCE Transplant Network® Facility In-Network	Out-of-Network		Cigna LifeSOURCE Transplant Network® Facility In-Network	Out-of-Network	
Organ Transplants	\$150 per admission copay	Not Covered		Plan pays 100%		Not Covered

Travel Lifetime Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: \$10,000 maximum per Transplant per Lifetime

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

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	\$150 per admission copay, then plan pays 100%	\$300 per admission deductible, then plan pays 70% ^	\$20 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Substance Use Disorder	\$150 per admission copay, then plan pays 100%	\$300 per admission deductible, then plan pays 70% ^	\$20 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^

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

Note: Detox is covered under medical

- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

Pharmacy**In-Network****Cost Share and Supply****Cigna Pharmacy Plus Cost Share**

- Retail – up to 30-day supply
- Home Delivery – up to 90-day supply

Retail (per 30-day supply):

Generic: You pay \$15
 Preferred Brand: You pay \$30
 Non-Preferred Brand: You pay \$45

Home Delivery (per 90-day supply):

Generic: You pay \$40
 Preferred Brand: You pay \$85
 Non-Preferred Brand: You pay \$130

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication.

Pharmacy Out-of-Pocket Maximum

- Retail and Home Delivery cost share applies to the Pharmacy Out-of-Pocket.

Individual: \$1,500
 Family: \$3,000

Drugs Covered**Prescription Drug List:**

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

Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

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 - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
 - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
 - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
 - Utilization and Unit Cost Management - prior authorization, quantity limits, and maximum daily dose for limited class(es) of specific medications.
- Prior authorization is required on specialty medications and quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

Pharmacy Cost Management Program

Step Therapy: Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

High Blood Pressure (ACEI/ARB), Cholesterol Lowering (STATIN), Heartburn/Ulcer (PPI), Bladder Problems (OAB), Osteoporosis (BONE), Non-Narcotic Pain Relievers (NSAID), ADD/ADHD (ADHD), Allergy (NASAL STEROIDS), Depression (SSRI/SNRI)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Sleep Disorders (HYPNOTICS), Mental Health (ATYPICAL PSYCHS), Asthma (ASTHMA)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Skin Conditions (TI), Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

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.

Comprehensive Oncology Program

- Care Management outreach
- Case Management

Included

Healthy Pregnancies/Healthy Babies

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

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

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 (110%) 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 Contract Year deductible and maximum reimbursable charge limitations.

Medicare Coordination

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

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

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

Multiple Surgical Reduction

In-Network - does not apply.

Out-of-Network - 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 - required for all inpatient admissions

In-Network: Coordinated by your physician

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

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

Additional Information

Pre-Certification - PHS+ 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.

- 50% 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 - 100

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

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

Holistic health support for the following chronic health conditions:

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

Definitions

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

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

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

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

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):

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Exclusions

- Care for health conditions that are required by state or local law to be treated in a public facility; provided, however, that this exclusion shall not operate to exclude coverage for services provided to a Member confined in a city or county jail or in a juvenile facility, solely because of such confinement, or for services provided to a Member while confined in a state hospital, solely because the services were provided in a state hospital.
- Services required by state or federal law to be supplied by a public school system or school district that are directed by or coordinated through the public school system or the school district rather than through a Participating Provider other than those services described under Section IV. Covered Services and Supplies, Autistic Disorders.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- 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.
- Any services and supplies for or in connection with experimental, investigational and unproven services as defined in "Section I. Definitions of Terms Used in this Group Service Agreement."
- Cosmetic surgery or therapy except as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies."
- The following services are excluded unless Medically Necessary:
 - o Macromastia or Gynecomastia Surgeries - Macromastia surgery is the surgical excision of enlarged female breast tissue, skin and fat in order to decrease the size of the breast. Gynecomastia surgery is a procedure to treat benign enlargement of the male breast;
 - o Surgical treatment of varicose veins;
 - o Abdominoplasty - Abdominoplasty, also referred to as a "tummy tuck" is a surgical procedure that tightens a lax anterior abdominal wall and removes excess abdominal skin (panniculectomy component). It is generally to improve appearance by recontouring the abdominal wall area;
 - o Panniculectomy - Panniculectomy is the surgical excision of redundant panniculus adiposus (the superficial fascia which contains an abundance of fat tissue);
 - o Rhinoplasty;
 - o Blepharoplasty - Blepharoplasty refers to the surgical excision of redundant tissues (muscle, fat, skin) of the eyelids;
 - o Redundant skin surgery;
 - o Removal of skin tags.
- The following services are excluded from coverage regardless of clinical indications:
 - o Acupressure;
 - o Craniosacral/cranial therapy - Craniosacral therapy (CST), also called cranial therapy, is an unproven non-invasive treatment that utilizes diagnostic touching to detect reported pulsations and rhythms of the flow of cerebrospinal fluid to effect a release of possible restrictions without the use of forceful manipulation. CST has been utilized for a variety of both musculoskeletal and general medical conditions. Some reported clinical applications of CST include acute systemic infections, chronic pain conditions, localized infection, dysfunctions of the viscera (e.g., ulcerative bowel conditions, asthma), depression, strabismus, auditory problems, developmental delay, and autism. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
 - o Dance therapy;
 - o Applied kinesiology - Applied kinesiology is a system using muscle testing as a functional neurological evaluation. The methodology is concerned primarily with neuromuscular function as it relates to the structural, chemical and mental physiologic regulatory mechanisms. A.K., which originated within the chiropractic profession, is an approach to clinical practice, with multidisciplinary applications. The safety and efficacy of this technique has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement

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Exclusions

- Provisions";
- o Rolting;
- o Prolotherapy - Prolotherapy is the injection of a solution for the purpose of tightening and strengthening loose or weak tendons, ligaments or joint capsules through the multiplication and activation of fibroblasts. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"; and
- o Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions - Extracorporeal shock wave therapy (ESWL) is a noninvasive treatment that involves delivery of 1000 to 3000 shock waves to the painful musculoskeletal region, and has been proposed as an alternative to surgery. The mechanism by which ESWL might work to relieve pain associated is unknown and the efficacy has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".
- 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. However, 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 (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least fifty (50%) percent bony support and are functional in the arch.
- Medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based scientific literature and scientifically-based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
 - o 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, unless Medically Necessary or as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies"; and
 - o Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
- Unless otherwise covered as a basic benefit, 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 being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
- Infertility services, infertility drugs, surgical or medical treatment programs for infertility.
- 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 and female voluntary sterilization procedures.
- Treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation. However, Medically Necessary treatment and penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services including but not limited to, Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs and driving safety. Behavioral training and services, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental

Exclusions

retardation are also excluded except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies."

- Consumable medical supplies other than ostomy supplies, urinary catheters and diabetic supplies. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies including skin preparations, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Diabetic Services", "Diabetic Supply Coverage", "Durable Medical Equipment" and "Home Health Services", sections of "Section IV. Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Section IV. Covered Services and Supplies." or unless determined to be Medically Necessary by the Healthplan Medical Director in consultation with the Member's treating Physician.
- 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 illness or injury.
- Artificial aids including, but not limited to, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Corrective orthopedic shoes, unless medically necessary or as specified in the "Orthoses and Orthotic Devices" section of "Section IV. Covered Services and Supplies".
- 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 non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Routine refraction.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All prescription drugs, non-prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, and investigational and experimental drugs (except as specified in "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"), and "Section IV. Covered Services and Supplies."
- 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.
- Dental implants for any condition.
- Genetic screening or pre-implantation 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, except as provided in the "Genetic Testing" section of "Section IV. Covered Services and Supplies."
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director'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 are excluded, except for infant formula needed for the treatment of inborn errors of metabolism and as specified under the "Phenylketonuria (PKU) Testing and Treatment" provision of Section IV. Covered Services and Supplies.
- 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.

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EHB State: CA

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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Cigna:

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

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

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

a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

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



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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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