CLIENT SUMMARY OF BENEFITS

Cigna HealthCare of Texas, Inc.
For - Transport Workers Union - MTA Health & Welfare Trust (TWU)
HMO Plan

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Coinsurance	Plan pays 80% coinsurance
Contract Year 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.	Individual: None Family: None
Contract Year 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 plan deductible, member paid coinsurance and copays.	Individual: $2,500 Family: $5,000
Pre-Existing Condition Limitation (PCL)	Not Applicable
Pre-certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions	Coordinated by your physician
Pre-certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing	Coordinated by your physician

Benefit	In-Network
Physician Services	
Primary Care Physician (PCP) Office Visit	$20 PCP copay; then Plan pays 100%
Specialty Care Physician Office Visit	$40 Specialist copay; then Plan pays 100%
Surgery Performed in Physician's Office	$20 PCP or $40 Specialist copay; then Plan pays 100%
Allergy Treatment/Injections	Lesser of $20 PCP or $40 Specialist copay or actual charge, then Plan pays 100%

Benefit	In-Network
Physician Services	
Allergy Serum Dispensed by the physician in the office	Plan pays 100%

Benefit	In-Network
Preventive Care	
Routine Preventive Care 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%
Immunizations	Plan pays 100%
Mammogram, PAP, PSA Tests • Coverage includes the associated Preventive Outpatient Professional Services. • 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%

Benefit	In-Network
Inpatient	
Inpatient Hospital Facility **Semi-Private Room:** Limited to the semi-private negotiated rate **Private Room:** Limited to the semi-private negotiated rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to the negotiated rate	Plan pays 80% coinsurance
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Multiple Surgical Reduction	Not Applicable

Benefit	In-Network
Outpatient	
Outpatient Facility Services	Plan pays 80% coinsurance

Benefit	In-Network
Outpatient	
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Short-Term Rehabilitation Per Contract Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days • Chiropractic Care – 20 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	$20 PCP or $40 Specialist copay; then Plan pays 100%

Benefit	In-Network
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) • Unlimited days maximum per Contract Year • 16 hour maximum per day	Plan pays 100%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Contract Year	Plan pays 80% coinsurance
Durable Medical Equipment	Plan pays 100% Unlimited maximum per Contract Year
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%
External Prosthetic Appliances (EPA)	Plan pays 100% Unlimited maximum per Contract Year
Routine Foot Disorders	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary.

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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Lab and X-ray	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Covered under plan's Inpatient Hospital benefit
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	Plan pays 100%	Plan pays 80% coinsurance	Plan pays 100%	Not Applicable	Plan pays 80% coinsurance

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	**In-Network**	**In-Network**	**In-Network**
Emergency Care	$20 PCP or $40 Specialist copay; then Plan pays 100%	$150 per visit (copay waived if admitted); then Plan pays 100%	Plan pays 100%	Plan pays 100%
* 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	**In-Network**	**In-Network**	**In-Network**
Urgent Care	$20 PCP or $40 Specialist copay; then Plan pays 100%	$50 per visit (copay waived if admitted); then Plan pays 100%	Plan pays 100%	Plan pays 100%
* 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	**In-Network**	**In-Network**	**In-Network**
Maternity	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 100%	$20 PCP or $40 Specialist copay; then Plan pays 100%	Covered same as plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.		
Benefit	**Inpatient Hospital and Other Health Care Facilities**	**Outpatient Services**
	In-Network	**In-Network**
Hospice (provided as part of Hospice Care Program)	Plan pays 80% coinsurance	Plan pays 100%
Bereavement Counseling (Services provided as part of Hospice Care Program)	Plan pays 80% coinsurance	Plan pays 100%

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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Abortion (Non-elective procedures)	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%

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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Family Planning - Men's Services	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals).					
Contraceptive devices as ordered or prescribed by a physician.					
Infertility	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	**Radiologists, Pathologists, Anesthesiologists:** Plan pays 100% **Surgeons:** 50% coinsurance	**Radiologists, Pathologists, Anesthesiologists:** Plan pays 100% **Surgeons:** 50% coinsurance
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.					

Place of Service - You pay based on where you receive services.		
Benefit	**Inpatient Hospital Facility**	**Inpatient Professional Services**
	Lifesource Facility In-Network	**Lifesource Facility In-Network**
Organ Transplants	Plan pays 80% coinsurance	Plan pays 100%
Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime		

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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Dental Care	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
TMJ, Surgical and Non-Surgical	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	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Bariatric Surgery	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Breast Reduction - Covered when medically necessary	$20 PCP or $40 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Surgeon Charges Lifetime Maximum: $10,000					

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	**In-Network**	**In-Network**
Mental Health	Plan pays 80% coinsurance	$20 copay, then Plan pays 100%	Plan pays 100%
• Unlimited maximum per Contract 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	**In-Network**	**In-Network**
Substance Abuse	Plan pays 80% coinsurance	$20 copay, then Plan pays 100%	Plan pays 100%
Note: Detox is covered under medical • Unlimited maximum per Contract 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.

Pharmacy	In-Network
Cigna Pharmacy Plus three-tier copay plan • When patient requests brand drug, patient pays the generic copay plus the cost difference between the brand and generic drugs up to the cost of the brand drug. • Self Administered injectable drugs - excludes infertility drugs • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Lifestyle drugs included - limited to sexual dysfunction • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes included	**Retail** - 31 day supply Generic: You pay $10 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 **Home delivery** - 90 day supply Generic: You pay $25 Preferred Brand: You pay $62 Non-Preferred Brand: You pay $125

Pharmacy	In-Network
Pharmacy Clinical Management and Prior Authorization • Your plan is subject to certain clinical edits and prior authorization requirements. • Refill-too-soon and 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: o Benefits Exclusion - prior authorization, age edits and quantity over time edits. o Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits. o Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.	
Specialty Pharmacy Management: • Clinical Programs o Prior authorization is required on specialty medications but quantity limits may apply. o Theracare® Program • Medication Access Option o Retail and/or Home Delivery	

Additional Information

Prescription Drug List:

- Cigna Standard Prescription Drug List

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

Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester)
Comprehensive Oncology Program • Care Management outreach • Case Management	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.
Laboratory and pathology tests

Dollars & Sense

(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.
- 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.
- 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 also 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.
- 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, 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 and developmental delays except as provided in this plan.
- 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.
- 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).

Exclusions

- 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, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements 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.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

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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For - Transport Workers Union - MTA Health & Welfare Trust (TWU)
HMO Open Access Plan

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Benefit	In-Network
Inpatient	
Inpatient Hospital Facility Semi-Private Room: Limited to the semi-private negotiated rate Private Room: Limited to the semi-private negotiated rate Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)): Limited to the negotiated rate	Plan pays 80% coinsurance
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Multiple Surgical Reduction	Not Applicable

Benefit	In-Network
Outpatient	
Outpatient Facility Services	Plan pays 80% coinsurance

Benefit	In-Network
Outpatient	
Outpatient Professional Services For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Short-Term Rehabilitation Per Contract Year Maximums: Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days Chiropractic Care – 20 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	$25 PCP or $50 Specialist copay; then Plan pays 100%
Short-Term Rehabilitation Per Contract YearMaximums: Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – Unlimited days for all therapies combined Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum	$25 PCP or $50 Specialist copay; then Plan pays 100%

Benefit	In-Network
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) Unlimited days maximum per Contract Year 16 hour maximum per day	Plan pays 100%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility 60 days maximum per Contract Year	Plan pays 80% coinsurance
Durable Medical Equipment	Plan pays 100% Unlimited maximum per Contract Year
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%

Benefit	In-Network
Other Health Care Facilities/Services	
External Prosthetic Appliances (EPA)	Plan pays 100% Unlimited maximum per Contract Year
Routine Foot Disorders	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary.

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	In-Network	In-Network	In-Network	In-Network
Lab and X-ray	Plan pays 100%	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%	Covered under plan's Inpatient Hospital benefit
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	Plan pays 100%	Plan pays 80% coinsurance	Plan pays 100%	Not Applicable	Plan pays 80% coinsurance

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	In-Network	In-Network	In-Network
Emergency Care	$25 PCP or $50 Specialist copay; then Plan pays 100%	$200 per visit (copay waived if admitted); then Plan pays 100%	Plan pays 100%	Plan pays 100%

* 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	In-Network	In-Network	In-Network
Urgent Care	$25 PCP or $50 Specialist copay; then Plan pays 100%	$100 per visit (copay waived if admitted); then Plan pays 100%	Plan pays 100%	Plan pays 100%

* 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	In-Network	In-Network	In-Network
Maternity	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 100%	$25 PCP or $50 Specialist copay; then Plan pays 100%	Covered same as plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.		
Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	In-Network	In-Network
Hospice (provided as part of Hospice Care Program)	Plan pays 80% coinsurance	Plan pays 100%
Bereavement Counseling (Services provided as part of Hospice Care Program)	Plan pays 80% coinsurance	Plan pays 100%

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	In-Network	In-Network	In-Network	In-Network
Abortion (non-elective procedures)	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%

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	In-Network	In-Network	In-Network	In-Network
Family Planning - Men's Services	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals).					
Contraceptive devices as ordered or prescribed by a physician.					

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	In-Network	In-Network	In-Network	In-Network
Infertility	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Radiologists, Pathologists, Anesthesiologists: Plan pays 100% Surgeons: 50% coinsurance	Radiologists, Pathologists, Anesthesiologists: Plan pays 100% Surgeons: 50% coinsurance
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.					

Place of Service - You pay based on where you receive services.		
Benefit	Inpatient Hospital Facility	Inpatient Professional Services
	Lifesource Facility In-Network	Lifesource Facility In-Network
Organ Transplants	Plan pays 80% coinsurance	Plan pays 100%
Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime		

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	In-Network	In-Network	In-Network	In-Network
Dental Care	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
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	In-Network	In-Network	In-Network	In-Network
TMJ, Surgical and Non-Surgical	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	In-Network	In-Network	In-Network	In-Network
Bariatric Surgery	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Breast Reduction - covered when medically necessary	$25 PCP or $50 Specialist copay; then Plan pays 100%	Plan pays 80% coinsurance	Plan pays 80% coinsurance	Plan pays 100%	Plan pays 100%
Surgeon Charges Lifetime Maximum: $10,000					
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	In-Network	In-Network
Mental Health	Plan pays 80% coinsurance	$25 copay, then Plan pays 100%	Plan pays 100%
Unlimited maximum per Contract 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	In-Network	In-Network
Substance Abuse	Plan pays 80% coinsurance	$25 copay, then Plan pays 100%	Plan pays 100%
Note: Detox is covered under medical Unlimited maximum per Contract 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.

Pharmacy	In-Network
Cigna Pharmacy Plus three-tier copay plan Generic Push Self Administered injectable drugs - excludes infertility drugs Includes Oral Contraceptives - with specific products covered 100% Lifestyles drugs - Limited to sexual dysfunction Insulin, glucose test strips, lancets, insulin needles & syringes included Oral fertility drugs included	Retail - 30 day supply Generic: You pay $10 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 Home delivery - 90 day supply Generic: You pay $25 Preferred Brand: You pay $62 Non-Preferred Brand: You pay $125

Pharmacy Clinical Management and Prior Authorization

Refill-too-soon and plan exclusion edits are always included.

Additional clinical management -Ehnanced package- a group of clinical medication management options that focus on various drgus use management phiolosphies to help actively manage the pharmacy benefit include.

Your plan is subject to certain clinical edits and prior authorization requirements.

Benefits Exclusion - Prior authorization, age edits and quantity over time edits.

Intensive Appropriateness of Use - duration of therapy edits, step and new market entrants, and does optimization edits.

Utilization and Unit Cost Management - prior authorization, quantity limits, maxmum daily dose, and step therapy for limited class (es) specific medications.

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

Prescription Drug List:

Cigna Standard Prescription Drug List

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
Healthy Pregnancies/Healthy Babies Care Management outreach Maternity Case Management Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester)
Comprehensive Oncology Program Care Management outreach Case Management	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.

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.

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: 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.

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 also 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.

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

Exclusions

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, 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 and developmental delays except as provided in this plan.

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.

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, weight loss programs and smoking cessation programs.

Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

Dental implants for any condition.

Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

Blood administration for the purpose of general improvement in physical condition.

Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

Cosmetics, dietary supplements 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.

Exclusions

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.
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.

Cigna Health and Life Insurance Co.: Open Access Plus

Coverage Period: 09/01/2014 - 08/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | **Plan Type:** OAP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$1,000** person / **$2,000** family For out-of-network providers **$2,000** person / **$4,000** family Does not apply to in-network preventive care , in-network office visits , prescription drugs Co-payments don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, **$250** for out-of-network outpatient hospital visit and **$500** per admission for out-of-network hospital stay and **$200** deductible per type of scan per day for out-of-network imaging (CT/PET scans, MRIs) There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$3,000** person / **$6,000** family / For out-of-network providers **$6,000** person / **$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, prescription drug co-payments, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 co-pay/visit	50% co-insurance	----------none----------
	Specialist visit	$80 co-pay/visit	50% co-insurance	----------none----------
	Other practitioner office visit	$80 co-pay/visit for chiropractor	50% co-insurance	Coverage for Chiropractic care and Rehabilitation services is limited to 20 days annual max.
	Preventive care/screening/ immunization	No charge	50% co-insurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	50% penalty for no precertification.
	Imaging (CT/PET scans, MRIs)	$100 co-pay per type of scan/day, plus 30% co-insurance	$200 deductible per type of scan/day, plus 50% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$10 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)	50% co-insurance	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	$25 co-pay/prescription (retail), $62 co-pay/prescription (home delivery)	50% co-insurance	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
	Non-preferred brand drugs	$50 co-pay/prescription (retail), $125 co-pay/prescription (home delivery)	50% co-insurance	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 co-pay/visit, plus 30% co-insurance	$250 deductible/visit, plus 50% co-insurance	50% penalty for no precertification. Per visit co-pay/deductible is waived for non-surgical procedures
	Physician/surgeon fees	30% co-insurance	50% co-insurance	50% penalty for no precertification.
If you need immediate medical attention	Emergency room services	$300 co-pay/visit	$300 co-pay/visit	Per visit co-pay is waived if admitted
	Emergency medical transportation	30% co-insurance	30% co-insurance	----------none----------
	Urgent care	$150 co-pay/visit	$150 co-pay/visit	Per visit co-pay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/admission, plus 30% co-insurance	$500 deductible/admission, plus 50% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$80 co-pay/visit	50% co-insurance	50% penalty for no precertification.
	Mental/Behavioral health inpatient services	$500 co-pay/admission, plus 30% co-insurance	$500 deductible/admission, plus 50% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	$80 co-pay/visit	50% co-insurance	50% penalty for no precertification.
	Substance use disorder inpatient services	$500 co-pay/admission, plus 30% co-insurance	$500 deductible/admission, plus 50% co-insurance	50% penalty for no precertification.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	----------none----------
	Delivery and all inpatient services	$500 co-pay/admission, plus 30% co-insurance	$500 deductible/admission, plus 50% co-insurance	50% penalty for no precertification.
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	50% penalty for no precertification.
	Rehabilitation services	$80 co-pay/visit	50% co-insurance	50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 20 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	30% co-insurance	50% co-insurance	50% penalty for no precertification. Coverage is limited to 60 days annual max
	Durable medical equipment	30% co-insurance	50% co-insurance	50% penalty for no precertification.
	Hospice services	30% co-insurance	50% co-insurance	50% penalty for no precertification.
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Eye care (Children) • Habilitation services	• Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine foot care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care • Infertility treatment		

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Texas Department of Insurance at 1-800-252-3439.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,450
- **Patient pays:** $3,090

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$1,000
Co-pays	$600
Co-insurance	$1,460
Limits or exclusions	$30
Total	**$3,090**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,990
- **Patient pays:** $1,410

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$140
Co-pays	$990
Co-insurance	$0
Limits or exclusions	$280
Total	**$1,410**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Plan Name: 6330-OAP- OPEN ACCESS PLUS COPAY

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