

## SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.  
For - City of Memphis  
Open Access Plus Premier Plan**

**Notice of Grandfathered Plan Status** This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html). If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

**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](http://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](http://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
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Coinsurance</b>	Your plan pays 100%	Your plan pays 60%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Calendar Year Deductible</b>	Individual: \$100 Family: \$300	Individual: \$500 Family: \$1,500
<ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.</li> <li>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.</li> </ul>		
Note: Services where plan deductible applies are noted with a caret (^)		

Plan Highlights		In-Network	Out-of-Network
<b>Calendar Year Out-of-Pocket Maximum</b>		Individual: \$3,000 Family: \$7,000	Individual: \$3,000 Family: \$7,000
<ul style="list-style-type: none"> <li>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.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.</li> <li>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.</li> </ul>			
Benefit	In-Network	Out-of-Network	
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>			
<b>Physician Services</b>			
<b>Physician Office Visit</b>	\$20 Primary Care Physician (PCP) copay ^ or \$40 Specialist copay ^	Your plan pays 60% ^	
<ul style="list-style-type: none"> <li>All services including Lab &amp; X-ray</li> <li>Plan pays 100% after you pay copay</li> <li>OB/GYN is subject to the \$20 PCP copay</li> </ul>			
<b>Surgery Performed in Physician's Office</b>	\$20 PCP or \$40 Specialist copay ^	Your plan pays 60% ^	
<b>Allergy Treatment/Injections</b>	Your plan pays 100%	Your plan pays 60% ^	
<b>Allergy Serum</b> Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 60% ^	
<b>Preventive Care</b>			
<b>Preventive Care</b>	Your plan pays 100%	Not covered	
<ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> </ul>			
<b>Immunizations</b>	Your plan pays 100%	Not covered	
<b>Mammogram, PAP, and PSA Tests</b>	Preventive: Your plan pays 100% Diagnostic: Your plan pays 100%	Preventive: Not covered Diagnostic: Your plan pays 60% ^	
<ul style="list-style-type: none"> <li>Coverage includes the associated Outpatient Professional Services.</li> </ul>			
<b>Inpatient</b>			
<b>Inpatient Hospital Facility</b>	\$100 per admission copay, then your plan pays 100% ^	\$300 per admission deductible, then your plan pays 60% ^	
<b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate			
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Your plan pays 100% ^	Your plan pays 60% ^	
<b>Inpatient Professional Services</b>	Your plan pays 100% ^	Your plan pays 60% ^	
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>			

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>		
<b>Outpatient</b>		
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible</li> </ul>	\$100 per facility visit copay, then your plan pays 100% ^	Your plan pays 60% ^
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Your plan pays 100% ^	Your plan pays 60% ^
<b>Short-Term Rehabilitation</b> Calendar Year Maximums: <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 60 days</li> <li>Cardiac Rehabilitation - 36 days</li> </ul> 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 ^	Your plan pays 60% ^
<b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>20 days maximum per Calendar Year</li> </ul>	\$20 PCP or \$40 Specialist copay ^	Not covered
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>Unlimited days maximum per Calendar Year</li> <li>16 hour maximum per day</li> </ul>	Your plan pays 100% ^	Your plan pays 60% ^
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>70 days maximum per Calendar Year</li> </ul>	Your plan pays 100% ^	Your plan pays 60% ^
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 100% ^	Not covered
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>Includes related supplies</li> </ul>	Your plan pays 100%	Not covered
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>\$200 EPA annual deductible per Calendar Year</li> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 100% ^	Not covered
<b>Enteral Formulas</b>	Your plan pays 100% ^	Your plan pays 60% ^

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>		
<b>Eye Care Services</b>	First routine or non-routine eye exam: Your plan pays 100% Subsequent routine eye exam: Your plan pays 100% Subsequent non-routine eye exam: \$20 copay ^	Routine eye exam: Not covered Diagnostic eye exam: Your plan pays 60% ^
<b>Medically Necessary Services</b> <ul style="list-style-type: none"> <li>Includes Rhinoplasty if deemed medically necessary</li> <li>Includes Blepharoplasty if deemed medically necessary</li> </ul>	Your plan pays 100% ^	Your plan pays 60% ^
<b>Hearing Aids for Children</b> <ul style="list-style-type: none"> <li>Maximum of 2 devices (1 per ear) every 3 years</li> <li>Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level.</li> <li>Coverage through age 17</li> </ul>	Your plan pays 100%	Your plan pays 100%, up to \$1,000 per device
<b>Hearing Aids for Adults</b> <ul style="list-style-type: none"> <li>\$5,000 maximum every 3 Calendar Years</li> <li>Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level.</li> <li>Coverage for age 18 and above</li> </ul>	Your plan pays 100% ^	Not covered
<b>Outpatient FS Infusion</b> <ul style="list-style-type: none"> <li>Includes dialysis, intravenous chemotherapy and other infusion therapies</li> </ul>	\$20 copay ^	Your plan pays 60% ^
<b>Routine Foot Disorders</b>	Not covered	Not covered

Note: Services associated with foot care for diabetes and peripheral vascular disease are covered In-Network only when deemed 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
<b>Lab and X-ray</b>	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100% ^		Plan pays 100%	Plan pays 60% ^
<b>Advanced Radiology Imaging</b>	Plan pays 100%	Plan pays 60% ^	Not Applicable	Not Applicable	Plan pays 100% ^		Plan pays 100% ^	Plan pays 60% ^

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
<b>Emergency Care</b>	\$200 per visit (copay waived if admitted) ^		Plan pays 100% ^		Plan pays 100% ^	
<b>Urgent Care</b>	\$30 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
<b>Hospice</b>	Plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^
<b>Bereavement Counseling</b>	Plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^

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
<b>Maternity</b>	\$20 copay ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

- Coverage is limited to Employee and Dependent Spouse only; only includes coverage of complications for Dependent Children.

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
<b>Abortion (Non-elective procedures)</b>	\$20 PCP or \$40 Specialist copay ^	Plan pays 60% ^	\$100 per admission copay, then plan pays 100% ^	\$300 per admission deductible, then plan pays 60% ^	\$100 per facility visit copay, then plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^
<b>Family Planning - Men's Services</b>	\$20 PCP or \$40 Specialist copay ^	Plan pays 60% ^	\$100 per admission copay, then plan pays 100% ^	\$300 per admission deductible, then plan pays 60% ^	\$100 per facility visit copay, then plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 60% ^

Includes surgical services, such as vasectomy (excludes reversals)

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
<b>Family Planning - Women's Services</b>	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	\$300 per admission deductible, then plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
<b>Infertility</b> <b>Note:</b> 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.										
<b>TMJ, Surgical and Non-Surgical</b>	\$20 PCP or \$40 Specialist copay ^	Not covered	\$100 per admission copay, then plan pays 100% ^	Not covered	\$100 per facility visit copay, then plan pays 100% ^	Not covered	Plan pays 100% ^	Not covered	Plan pays 100% ^	Not covered
Services provided on a case-by-case basis. Subject to medical necessity. Unlimited maximum per lifetime										
<b>Bariatric Surgery</b>	\$20 PCP or \$40 Specialist copay ^	Not covered	\$100 per admission copay, then plan pays 100% ^	Not covered	\$100 per facility visit copay, then plan pays 100% ^	Not covered	Plan pays 100% ^	Not covered	Plan pays 100% ^	Not covered
<b>Surgeon Charges Lifetime Maximum:</b> Unlimited Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: <ul style="list-style-type: none"> <li>• 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.</li> <li>• weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision</li> </ul>										
Note: Services where plan deductible applies are noted with a caret (^)										
Benefit	Inpatient Hospital Facility			Inpatient Professional Services						
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network				
<b>Organ Transplants</b>	\$100 per admission copay	\$100 per admission copay, then plan pays 100% ^	Not covered	Plan pays 100%	Plan pays 100% ^	Not covered				
Travel Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant Note: Services where plan deductible applies are noted with a caret (^)										

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Benefit	Inpatient		Outpatient - Physician's Office		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Mental Health</b>	\$100 per admission copay, then plan pays 100% ^	\$300 per admission deductible, then plan pays 60% ^	\$40 copay ^	Plan pays 60% ^	\$40 copay ^	Plan pays 60% ^
<b>Substance Abuse</b>	\$100 per admission copay, then plan pays 100% ^	\$300 per admission deductible, then plan pays 60% ^	\$40 copay ^	Plan pays 60% ^	\$40 copay ^	Plan pays 60% ^

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

**Note:** Detox is covered under medical

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

## Mental Health and Substance Abuse Services

### Mental Health/Substance Abuse Utilization Review, Case Management and Programs

Cigna Behavioral Advantage - Inpatient and Outpatient Management

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

## Pharmacy

Pharmacy benefits not provided by Cigna

## 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.

### Health Advisor - A

Support for healthy and at-risk individuals to help them stay healthy

- Health and Wellness Coaching
- Gaps in Care coaching for select conditions
- Preference Sensitive Care/Treatment Decision Support Coaching

Included

## Additional Information

### Maximum Reimbursable Charge

Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (110%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

### Pre-Certification - Continued Stay Review - PHS+ Inpatient - 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.

### Pre-Certification - Continued Stay Review - 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.

## Additional Information

### 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

## Definitions

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

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

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

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

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

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

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

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

## Exclusions

this plan.

- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; 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 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 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 co-morbidities, or 35-39 with co-morbidities. The following are specifically 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; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational

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## Exclusions

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.
- 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).
- 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, and telemedicine.
- 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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