BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - CIEE, Inc.
Open Access Plus Plan
OAP
Effective - 01/01/2022

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

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

Tiered Benefits - This Tiered benefit plan provides an opportunity to lower your out of pocket costs by selecting Tier 1 providers in your plan's network. Physicians designated as a Tier 1 provider promote quality, cost effective care. The "Tier 1 Provider" designation applies to physicians from the following specialties

Primary Care Provider (PCP) Types: Family Practice Internal Medicine Pediatrics

Specialist Types:			
Allergy/Immunology	Endocrinology	Neurology	
Cardiology	Gastroenterology	Neurosurgery	Pulmonology
Cardio-Thoracic Surgery	General Surgery	OB/GYN	Rheumatology
Dermatology	Hematology	Ophthalmology	Urology
Ear/Nose/Throat (ENT)	Nephrology	Orthopedics/Surgery	

The In-Network benefits described in the summary below show benefit levels for care received from Tier 1 and Non-Tier 1 providers as applicable. If you select an in-network provider in one of the specialties above, who does not have the "Tier 1 Provider" designation, any covered services billed for by that physician will be covered at the Non-Tier 1 benefit level.

Covered services from Physicians not listed in one of the Specialist Types above are covered at the same benefit level as Non-Tier 1 providers.

Physicians that are Tier 1 designated providers are identified with "Tier 1 Provider" next to their name within our provider directories on cigna.com, mycigna.com, and Cigna's mobile app.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 80%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	200%
Plan Deductible	Individual: $500 Family: $1,500	Individual: $1,000 Family: $3,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

Plan Out-of-Pocket Maximum	Individual: $2,250 Family: $4,500	Individual: $6,000 Family: $11,000

- 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.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the 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.

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Physician Services - Office Visits			
Primary Care Physician (PCP) Services/Office Visit	$5 copay, and plan pays 100%	$25 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$20 copay, and plan pays 100%	$40 copay, and plan pays 100%	Plan pays 60% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).			
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Cigna Telehealth Connection Services (Virtual Care)	Not Applicable	$25 copay, and plan pays 100%	Not Covered
• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies. • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).			
Convenience Care Clinic			
Convenience Care Clinic	Not Applicable	$25 copay, and plan pays 100%	Plan pays 60% ^
Preventive Care			
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited			
Immunizations	Plan pays 100%	Plan pays 100%	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%	Plan pays 100%	Plan pays 100%
• 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.			
Inpatient			
Inpatient Hospital Facility Services	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs			
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services	Plan pays 80% ^ **Surgeon Only**	Plan pays 80% ^	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists • Covered services from Radiologists, Pathologists and Anesthesiologists are covered at the same benefit level as Non-Tier 1 providers.			

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Outpatient			
Outpatient Facility Services	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services	Plan pays 80% ^ **Surgeon Only**	Plan pays 80% ^	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists • Covered services from Radiologists, Pathologists and Anesthesiologists are covered at the same benefit level as Non-Tier 1 providers.			
Emergency Services			
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	Not Applicable	$150 copay, and plan pays 100%	$150 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Not Applicable	$50 copay, and plan pays 100%	$50 copay, and plan pays 100%
Ambulance	Not Applicable	Plan pays 80% ^	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.			
Inpatient Services at Other Health Care Facilities			
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services			
Physician's Services/Office Visit	Plan pays 100%	Plan pays 100%	Plan pays 60% ^
Independent Lab	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Radiology Services			
Physician's Services/Office Visit	Plan pays 100%	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.		
Outpatient Facility	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Outpatient Therapy Services			
Outpatient Therapy Services	Not Applicable	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • Speech Therapy - 60 days • Occupational Therapy and Physical Therapy - 60 days • All other therapies - Includes Cognitive Therapy and Pulmonary Rehabilitation - 60 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.			
Chiropractic Services	Not Applicable	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - 60 days			
Cardiac Rehabilitation Services	Not Applicable	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - Unlimited days			
Hospice			
Inpatient Facilities	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Note: Includes Bereavement counseling provided as part of a hospice program.			
Bereavement Counseling (for services not provided as part of a hospice program)			
Services Provided by a Mental Health Professional	Not Applicable	Covered under Mental Health benefit	Covered under Mental Health benefit

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Medical Specialty Drugs			
Outpatient Facility	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Physician's Office	Not Applicable	Plan pays 100%	Plan pays 60% ^
Home	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.			
Maternity			
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 100%	Plan pays 60% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Plan pays 100%	Plan pays 100%	Plan pays 60% ^
Delivery - Facility (Inpatient Hospital, Birthing Center)	Not Applicable	Plan pays 100%	Plan pays 60% ^
Abortion			
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures			
Family Planning			
Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)			
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)			

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Infertility			
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Not Covered
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: $25,000			
Outpatient Dialysis Services			
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Not Covered
Home Dialysis **Note:** Dialysis visits will not accumulate to Home Health Care maximum	Not Applicable	Covered same as plan's Home Health Care benefit	Not Covered
Outpatient Facility Services	Not Applicable	Covered same as plan's Outpatient Facility Services benefit	Not Covered
Outpatient Professional Services	Not Applicable	Covered same as plan's Outpatient Professional Services benefit	Not Covered
Other Health Care Facilities/Services			
Home Health Care	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
• Annual Limit: 100 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary			
Organ Transplants			
Inpatient Hospital Facility Services			
LifeSOURCE Facility	Not Applicable	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Not Applicable	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services			
LifeSOURCE Facility	Not Applicable	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime			
Durable Medical Equipment • Annual Limit: Unlimited	Not Applicable	Plan pays 80% ^	Plan pays 60% ^

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
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	Not Applicable	Plan pays 100%	Plan pays 60% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited Non-Surgical lifetime maximum	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.			
Bariatric Surgery • Unlimited lifetime limit	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Not Covered
Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision			
Routine Foot Care	Not Covered	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.			
Hearing Aids • Maximum of 2 devices per 36 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Wigs • Maximum of $500 per wig per Calendar year	Not Applicable	Plan pays 80% ^	Plan pays 80% ^
Acupuncture • Annual Limit: 20 days	Not Applicable	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network		Out-of-Network
	Tier 1 Providers	Non-Tier 1 Providers	
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.			
Mental Health and Substance Use Disorder			
Inpatient Mental Health	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Outpatient Mental Health – Physician's Office	Not Applicable	$20 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Mental Health – All Other Services	Not Applicable	Plan pays 100%	Plan pays 60% ^
Inpatient Substance Use Disorder	Not Applicable	Plan pays 80% ^	Plan pays 60% ^
Outpatient Substance Use Disorder – Physician's Office	Not Applicable	$20 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder – All Other Services	Not Applicable	Plan pays 100%	Plan pays 60% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

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.

Maximum Reimbursable Charge
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

Multiple Surgical Reduction
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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Additional Information

Pre-Certification - Continued Stay Review - Preferred Care Management 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.

- $750 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 - Preferred Care Management 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.

- $750 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 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.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
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.
- 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. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;

Exclusions

- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; 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 teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- 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.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- 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 and dentures.

Exclusions

- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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 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.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- 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, service agreement 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.

EHB State: ME