## SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Association of Universities for Research in Astronomy
Open Access Plus Plan

### Selection of a Primary Care Provider
- Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](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

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Your plan pays 100%</td>
<td>Your plan pays 80%</td>
</tr>
<tr>
<td><strong>Maximum Reimbursable Charge</strong></td>
<td>Not Applicable</td>
<td>110%</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,350</td>
<td>Individual: $2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$2,700</td>
<td>Family: $5,000</td>
</tr>
</tbody>
</table>

- 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 counts toward both your in-network and out-of-network deductibles.
- Copays always apply before plan deductible and coinsurance.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Generic prescription medications used to prevent any of the following medical conditions are not subject to the individual and/or family plan deductible: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.

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

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AZ
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AZBENSUM-ER

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1 of 17
### Plan Highlights

<table>
<thead>
<tr>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual: $1,350</td>
<td></td>
<td>Individual: $5,000</td>
</tr>
<tr>
<td>Family: $2,700</td>
<td></td>
<td>Family: $10,000</td>
</tr>
</tbody>
</table>

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

### Physician Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit – Primary Care Physician (PCP)</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Physician Office Visit – Specialist</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Surgery Performed in Physician’s Office - PCP</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Surgery Performed in Physician’s Office - Specialist</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Allergy Treatment/Injections Performed in Physician's Office PCP</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Allergy Treatment/Injections Performed in Specialist Office</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Allergy Serum - PCP</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Allergy Serum - Specialist</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna Telehealth Connection services</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

- Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)
- Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Plan pays 100%</td>
<td>PCP: After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td>Specialist: After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Plan pays 100%</td>
<td>PCP: After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist: After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Mammogram, PAP, and PSA Tests</td>
<td>Plan pays 100%</td>
<td>Plan pays based on place of service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Coverage includes the associated Preventive Outpatient Professional Services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Facility</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td></td>
<td>Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Physician’s Visit/Consultation</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td></td>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td></td>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
</tr>
<tr>
<td>Short-Term Rehabilitation - PCP</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation – Specialist</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td>- Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – 60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td>- Spinal Manipulation and Subluxation Services - Unlimited visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Health Care Facilities/Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td>(includes outpatient private duty nursing subject to medical necessity)</td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td>- Unlimited days maximum per Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 16 hour maximum per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td></td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td></td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td><strong>Breast Feeding Equipment and Supplies</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td></td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td>- Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</td>
<td>Your plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>- Includes related supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Prosthetic Appliances (EPA)</strong></td>
<td>After the plan deductible is met,</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td></td>
<td>your plan pays 100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>$20 per visit deductible, then plan pays</td>
<td>After the plan deductible is met,</td>
</tr>
<tr>
<td>- Limited to one exam per Calendar Year</td>
<td>100%</td>
<td>your plan pays 80%</td>
</tr>
<tr>
<td><strong>Routine Foot Disorders</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Medical Specialty Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td><strong>Physician's Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician’s Office. This benefit does not cover the related Office Visit or Professional charges.</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.</td>
<td>After the plan deductible is met, your plan pays 100%</td>
<td>After the plan deductible is met, your plan pays 80%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory</strong></td>
<td>Covered same as plan’s Physician’s Office Services</td>
<td>Plan pays 100%</td>
<td>Covered same as plan’s Emergency Room/Urgent Care Services</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td>Covered same as plan’s Physician’s Office Services</td>
<td>Not Applicable</td>
<td>Covered same as plan’s Emergency Room/Urgent Care Services</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>
### Place of Service - your plan pays based on where you receive services

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician’s Office</th>
<th>Independent Lab</th>
<th>Emergency Room/ Urgent Care Facility</th>
<th>Outpatient Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Advanced Radiology Imaging</td>
<td>Covered same as plan's Physician’s Office Services</td>
<td>Covered same as plan's Physician’s Office Services</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
<td>Covered same as plan's Emergency Room/Urgent Care Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Covered same as plan's Outpatient Facility Services</td>
<td>Covered same as plan's Outpatient Facility Services</td>
</tr>
<tr>
<td>Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Emergency Room / Urgent Care Facility</th>
<th>Outpatient Professional Services</th>
<th>*Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
<td>Not Applicable*</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Inpatient Hospital and Other Health Care Facilities</th>
<th>Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Hospice</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>Plan pays 100% ^</td>
<td>Plan pays 100% ^</td>
</tr>
</tbody>
</table>

Note: Services provided as part of Hospice Care Program

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Initial Visit to Confirm Pregnancy</th>
<th>Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges)</th>
<th>Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)</th>
<th>Delivery - Facility (Inpatient Hospital, Birthing Center)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Maternity</td>
<td>Covered same as plan’s Physician’s Office Services</td>
<td>Covered same as plan’s Physician’s Office Services</td>
<td>Plan pays 100% ^</td>
<td>Covered same as plan’s Physician’s Office Services</td>
</tr>
<tr>
<td></td>
<td>Plan pays 100% ^</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 80% ^</td>
<td>Plan pays 80% ^</td>
</tr>
</tbody>
</table>

Note: Services provided as part of Hospice Care Program

Note: Services where plan deductible applies are noted with a caret (^).
### Abortion (Elective and non-elective procedures)
- Covered same as plan's Physician's Office Services
- Covered same as plan's Physician's Office Services
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^

Includes surgical services, such as vasectomy (excludes reversals)

**Family Planning - Men's Services**
- Covered same as plan's Physician's Office Services
- Covered same as plan's Physician's Office Services
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^

**Family Planning - Women's Services**
- Plan pays 100%
- Covered same as plan's Physician's Office Services
- Plan pays 100%
- Plan pays 80% ^
- Plan pays 100%
- Plan pays 80% ^
- Plan pays 100%
- Plan pays 80% ^

Includes surgical services, such as tubal ligation (excludes reversals)
Contraceptive devices as ordered or prescribed by a physician.

**Infertility**
*Note:* Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

**Bariatric Surgery**
- Covered same as plan's Physician's Office Services
- Covered same as plan's Physician's Office Services
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^
- Plan pays 100% ^
- Plan pays 80% ^

**Surgeon Charges Lifetime Maximum: Unlimited**

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.
### Benefit Summary

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Inpatient Professional Services</th>
<th>Outpatient Professional Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
</tbody>
</table>

#### Notes:
- Services where plan deductible applies are noted with a caret (^).
- Travel Maximum - Lifesource Facility: Unlimited
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization.

### Mental Health and Substance Use Disorder Services

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management
- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Narcotic Therapy Management
- Complex Psychiatric Case Management

### Pharmacy

<table>
<thead>
<tr>
<th>Cost Share and Supply</th>
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</thead>
<tbody>
<tr>
<td>In-Network</td>
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</tbody>
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AZBENSUM-ER
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<table>
<thead>
<tr>
<th></th>
<th>Pharmacy</th>
<th>In-Network</th>
<th>Out-of-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Cigna Pharmacy Cost Share</strong></td>
<td></td>
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</tr>
<tr>
<td>- Retail – up to 90-day supply (except Specialty up to 30-day supply)</td>
<td>Retail (per 30-day supply): Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0%</td>
<td>Retail: You pay 50% Your plan pays 50%</td>
<td></td>
</tr>
<tr>
<td>- Home Delivery – up to 90-day supply</td>
<td>Retail (per 90-day supply): Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0%</td>
<td>Home Delivery: Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Delivery (per 90-day supply): Generic: You pay 0% Preferred Brand: You pay 0% Non-Preferred Brand: You pay 0%</td>
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<tr>
<td>- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.</td>
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<tr>
<td>- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.</td>
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<tr>
<td>- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.</td>
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<tr>
<td>- When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.</td>
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<tr>
<td>- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.</td>
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</tbody>
</table>

**Generic Preventive Drugs:**

In-Network Preventive drugs and products will not be subject to deductible. In addition, Federally required preventive drugs will not be subject to deductible and will be provided at no charge. This applies to drugs for:

- Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency
**Additional Drugs Covered**

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

Some highlights:
- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Non-Sedating Anti-histamines are not covered.
- Ulcer Drugs (Proton Pump Inhibitors/PPI) are not covered.

**Pharmacy Program Information**

**Pharmacy Clinical Management and Prior Authorization**
- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.
- Prior authorization is required on specialty medications and quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it’s important to take their medications exactly as prescribed by a physician.

**Pharmacy Cost Management Program**

**Step Therapy:** Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.
- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

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

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
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</table>
| **Bladder Problems (OAB)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Osteoporosis (BONE)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Sleep Disorders (HYPNOTICS)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Allergy (NASAL STEROIDS)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Depression (SSRI/SNRI)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Skin Conditions (TI)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Mental Health (ATYPICAL PSYCHS)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
| **Non-Narcotic Pain Relievers (NSAID)** | - Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.  
  - Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.  
  - Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill. |
Pharmacy Program Information

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

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

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

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 Assessments
- Health and Wellness Coaching
- Gaps in Care Coaching
- Treatment Decision Support
- Educate and Refer

Included

Healthy Pregnancies/Healthy Babies
- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

$150 (1st trimester) / $75 (2nd trimester) - Option 3
## 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.

## Medicare Coordination
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 as permitted by the Social Security Act of 1965** 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.

This plan will pay as the Secondary Plan to Medicare Part A and B **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.

## 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 - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.
- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

## Pre-Existing Condition Limitation (PCL) does not apply.
Your Health First - 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 accessible.
Exclusions

- 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 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 Service (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 Service, 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 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.
- 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 or unproven services do not include Routine Patient Services related to approved clinical trials as described in your plan document.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - 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;
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - The subject of an ongoing phase I, II, III or IV clinical trial, except for Routine Patient Services as provided in the "Clinical Trials" section of this plan;
  - The subject of review or approval by an Institutional Review Board of an academic health institution in the State of Arizona, except for Routine Patient Services as provided in the "Clinical Trials" section of this plan.
- 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.
- Surgical or nonsurgical treatment of TMJ disorders.
- 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, 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.
Exclusions

- 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.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities or developmental delays.
- 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
Exclusions

- 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.
- For nutritional or dietary supplements, unless those charges are for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Charges for an off-label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if: the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature; and the drug has not been determined by the FDA to be contradicted for the specific type of cancer being treated. Coverage will also be provided for any medical services necessary to administer the drug.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Audio only telephone, e-mail, video only system, fax machine and instant message 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.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

EHB State: AZ
Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Proficiency of Language Assistance Services

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

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

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


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


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

Arabic – توجه: خدمات كمك زبانية، هي متوفرة على مدار الساعة، مجاناً، لعملاء Cigna الحاليين. لعملاء Cigna - Arabic: أنصل ب 1.800.244.6224 (أصل ب 711).


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

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

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

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


Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna شماره 1.800.244.6224 را به صورت رایگان پیگیری کنید.