SUMMARY OF COVERAGE

This is a summary of benefits for your Open Access Plus plan. Deductibles cross accumulate amongst Tiers I and II only. Out-of-Pocket Maximums cross accumulate amongst Tiers I and II only.

Cigna HealthCare Benefit Summary
SCL Health Effective 1/1/2018
PPO Plan

BENEFIT HIGHLIGHTS	TIER I - IN-NETWORK – CSN Providers	TIER II - IN-NETWORK – All Other CIGNA contracted Facilities/Physicians	TIER III - OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Coinsurance Levels	85%	70%	50% of Reasonable & Customary
R & C Percentile	Contracted Rate	Contracted Rate	80th Percentile
Calendar Year Deductible *Individual*	$1,250 per person	$2,500 per person	$5,000 per person
Family Maximum	$2,500 per person	$5,000 per family	$10,000 per family
Deductible Accumulators: *Cross accumulate amongst Tiers I and II only.*			
Annual Out-of-Pocket Maximum			
Includes Deductible	Yes	Yes	Yes
Includes Copays	Yes	Yes	N/A
Individual	$2,500 per person	$5,000 per person	$10,000
Family Maximum	$5,000 per family	$10,000 per family	$20,000
Out-of-Pocket Accumulators: *Medical and Pharmacy Cross Accumulate amongst Tiers I and II only*			

Physician's Services			
Primary Care Physician's Office visit	No charge after $25 PCP per office visit copay; No charge after the PCP per office visit copay if only x-ray and/or lab services performed and billed.	No charge after $50 PCP per office visit copay; No charge after the PCP per office visit copay if only x-ray and/or lab services performed and billed.	50% after plan deductible
Specialty Care Physician's Office Visit Office Visits	No charge after $40 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed.	No charge after $75 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed.	50% after plan deductible
Surgery Performed In the Physician's Office	No charge after the PCP or Specialist per office visit copay	No charge after the PCP or Specialist per office visit copay	50% after plan deductible
Allergy Treatment/Injections	No charge after the PCP or Specialist per office visit copay	No charge after the PCP or Specialist per office visit copay	50% after plan deductible
Allergy Serum (dispensed in the doctor's office)	No charge	No charge	50% after plan deductible
Preventive Care *Including Immunizations*	100% no deductible	100%, no deductible	50% after plan deductible
Preventive Cancer Screenings	100% no deductible	100%, no deductible	50% after plan deductible
Routine Mammograms, PSA, Pap Smear	100% no deductible	100%, no deductible	50% after plan deductible
Diagnostic Mammogram	100%, no deductible - 1 per calendar year 85%, after plan deductible – subsequent procedures	100%, no deductible - 1 per calendar year 85%, after plan deductible – subsequent procedures	50% after plan deductible 50% after plan deductible
Preventive Colonoscopy	100% no deductible	100%, no deductible	50% after plan deductible
Diagnostic Colonoscopy	100%, no deductible - 1 per calendar year 85%, after plan deductible – subsequent procedures	100%, no deductible - 1 per calendar year 85%, after plan deductible – subsequent procedures	50% after plan deductible 50% after plan deductible

Treatment of Obesity			
Office Visit	No charge after the PCP or Specialist per office visit copay	No charge after the PCP or Specialist per office visit copay	Not Covered
Inpatient Facility	85% after plan deductible	70% after plan deductible	Not Covered
Outpatient Surgical Facility	85% after plan deductible	70% after plan deductible	Not Covered
Physician's Services	No charge after the PCP or Specialist per office visit copay	No charge after the PCP or Specialist per office visit copay	Not Covered
Dialysis Services	85% after plan deductible	70% after plan deductible	Not Covered
Inpatient Hospital - Facility Services	85% after plan deductible	70% after plan deductible	50% after plan deductible
Semi Private Room and Board	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate
Private Room	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate
Special Care Units (ICU/CCU)	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate	Limited to semi-private room negotiated rate

Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room*	85% after plan deductible	70% after plan deductible	50% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	85% after plan deductible	70% after plan deductible	50% after plan deductible
Inpatient Hospital Professional Services *Surgeon* *Assistant Surgeon*	85% after plan deductible 85% after plan deductible	70% after plan deductible 85% after Tier 1 plan	50% after plan deductible 85% after Tier 1 plan
Inpatient Hospital Professional Services *Radiologist Pathologist Anesthesiologist*	85% after plan deductible	85% after Tier 1 plan deductible	85% after Tier 1 plan deductible
Multiple Surgical Reduction Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The primary procedure is paid as any other surgery.			
Outpatient Professional Services *Surgeon* *Assistant Surgeon*	85% after plan deductible 85% after plan deductible	70% after plan deductible 85% after Tier 1 plan deductible	50% after plan deductible 85% after Tier 1 plan
Outpatient Professional Services *Radiologist* *Pathologist* *Anesthesiologist*	85% after plan deductible	85% after Tier 1 plan deductible	85% after Tier 1 plan deductible
Emergency and Urgent Care Services *Hospital Emergency Room** *Urgent Care Facility** Ambulance* **waived if admitted*	 $150 per visit copay*; 85% no plan deductible $50 per visit copay*; 85% no plan deductible 85% after plan deductible (Pay at Facility level when billed by a facility)	 $150 per visit copay; 85% no plan deductible $50 per visit copay; 85% no plan deductible 85% after plan deductible (Pay at Facility level when billed by a facility facility)	 $150 per visit copay; 85% no plan deductible $50 per visit copay; 85% no plan deductible 85% after Tier 1 plan deductible (Pay at Facility level when billed by a facility)
Inpatient Services at Other Health Care Facilities *Includes* ***Skilled*** ***Nursing Facility*** *and Sub-Acute Facilities* Unlimited days combined maximum per calendar year	85% after plan deductible	70% after plan deductible	50% after plan deductible
Laboratory and Radiology Services *(includes pre-admission testing)*	85% after plan deductible	70% after plan deductible	50% after plan deductible.

Advanced Radiology – MRI, CAT, MRAs & PET Scans			
Physician's Office	No charge after PCP or Specialist per visit copay	No charge after PCP or Specialist per visit copay	50% after plan deductible
Outpatient Hospital Facility *Emergency Room/Urgent Care Facility*	85% after plan deductible 85% no plan deductible	70% after plan deductible 85% no plan deductible	50% after plan deductible 85% no plan deductible

Independent X-ray and/or Lab Facility	85% after plan deductible	70% after plan deductible	50% after plan deductible
Outpatient Short-Term Rehabilitative Therapy (office setting) *Unlimited visits, covered as medically necessary* Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	85% after plan deductible	70% after plan deductible	50% after plan deductible
Chiropractic Treatment *20 days maximum per calendar year*	No charge after $75 specialist per office visit copay	No charge after $75 specialist per office visit copay	50% after plan deductible
Home Health Care Unlimited visits maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary) The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).	85% after plan deductible	70% after plan deductible	50% after plan deductible
Nutritional Counseling *6 visits per calendar year*	85% after plan deductible	70% after plan deductible	50% after plan deductible
Smoking Cessation *Includes patches and gum. $300 maximum per person per calendar year*	100% no deductible	100% no deductible	100% no deductible
Hospice *Inpatient Services and Outpatient Services*	100% no deductible	100% after plan deductible	50% after plan deductible

Maternity Care Services *Initial Visit to Confirm Pregnancy* *All Subsequent Prenatal Visits, Postnatal Visits, and Delivery (Includes C-section delivery)* *Delivery (Inpatient Hospital)*	No charge after PCP or Specialist per office visit copay 85% after plan deductible 85% after plan deductible	No charge after PCP or Specialist per visit copay 70% after plan deductible 70% after plan deductible	50% after plan deductible 50% after plan deductible 50% after plan deductible
Outpatient Surgical Facility	85% after plan deductible	70% after plan deductible	50% after plan deductible
Physician's Services	No charge after PCP or Specialist per office visit copay	No charge after PCP or Specialist per visit copay	50% after plan deductible
Infertility Treatment ***Office Visit for Diagnosis Only*** ***Services not covered include:*** • *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).* • *Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).* *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.*	No charge after PCP or Specialist per office visit copay	No charge after PCP or Specialist per visit copay	50% after plan deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants and organ procurement* *Inpatient Facility* *Physician's Services* *Travel Services* *$10,000 maximum* *(Includes both recipient and donor travel expenses)*	 N/A N/A N/A	 Lifesource Center: No charge, no deductible Lifesource Center: No charge, no deductible 70% after deductible Available only if Lifesource Facility is used	 In-Network coverage only In-Network coverage only In-Network coverage only
Durable Medical Equipment / External Prosthetic Appliances Calendar year maximum: Unlimited	85% after plan deductible	70% after plan deductible	50% after plan deductible
Acupuncture *20 days per calendar year*	No charge after $75 specialist per office visit copay	No charge after $75 specialist per office visit copay	50% after plan deductible
Hearing Aids *Limited to $3000 every 3 years*	85% after plan deductible	70% after plan deductible	50% after plan deductible
Wigs *$350 maximum* *Covered when hair loss due to medical conditions or treatments*	85% after plan deductible	85% after Tier 1 plan deductible	85% after Tier 1 plan deductible

Dental Care *Limited to charges made for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth. .* *Physician's Office* *Inpatient Facility* *Outpatient Surgical Facility* *Physician's Services*	 No charge after PCP or Specialist per office visit copay 85% after plan deductible 85% after plan deductible 85% after plan deductible	 No charge after PCP or Specialist per visit copay 70% after plan deductible 70% after plan deductible 70% after plan deductible	 50% after plan deductible 50% after plan deductible 50% after plan deductible 50% after plan deductible
Routine Foot Disorders	Not Covered	Not Covered	Not Covered
Mental Health *Inpatient* *Physicians Services* *Outpatient facility*	 85% after plan deductible No charge after PCP per office visit copay 85% after plan deductible	 85% after Tier 1 plan deductible No charge after Tier 1 PCP per office visit copay 85% after plan deductible	 50% after plan deductible 50% after plan deductible 50% after plan deductible
Substance Use Disorder *Inpatient* *Physician's Services* *Outpatient facility*	 85% after plan deductible No charge after PCP per office visit copay 85% after plan deductible	 85% after Tier 1 plan deductible No charge after Tier 1 PCP per office visit copay 85% after plan deductible	 50% after plan deductible 50% after plan deductible 50% after plan deductible
Prescription Drugs Administered by Cigna **All maintenance medications for 30, 60, 90 day supply MUST be filled through an SCL Health Pharmacy Network.** **Mail Order MUST be filled through Good Samaritan Pharmacy.** ***All specialty prescriptions MUST be filled through Franklin Pharmacy.** ***Diabetic Supplies – covered at 100% when filled through SCL Health Pharmacy Network***	**<u>SCL Owned Pharmacies – 30 day supply</u>** Generic - $10 copay Insulins - $30 copay Formulary - $45 copay Non-Formulary- 50% coinsurance up to a $125 maximum Specialty – 25% coinsurance up to a $250 maximum* Lifestyle Drugs – 100% member pay **<u>Maintenance Medications Mail Order – Good Samaritan Pharmacy ONLY</u>** Generic - $20 copay Insulins - $60 copay Formulary - $90 copay Non-Formulary-50% coinsurance up to $250 maximum Specialty – Not Covered* Lifestyle Drugs – 100% member pay	**<u>Cigna Retail Pharmacy – 30 day supply</u>** Generic - $17** Formulary - 25% coinsurance up to a $75 maximum** Non-Formulary-50% coinsurance no maximum** Specialty – Not Covered* Lifestyle Drugs – 100% member pay Not Covered	Not Covered
Pre-existing Condition Limitation (PCL)	None		

Pre-Admission Certification - Continued Stay Review (PHS+) *Inpatient Pre-Admission Certification* - Continued Stay Review (required for all inpatient admissions)	**Tier 1 & 2: Provider** is responsible for contacting Cigna Healthcare. **Tier 3:** Employee is responsible for contacting Cigna Healthcare. 0% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
Outpatient Pre Notification- (required for selected outpatient procedures and diagnostic testing).	**Tier 1 & 2: Provider** is responsible for contacting Cigna Healthcare. **Tier 3:** Employee is responsible for contacting Cigna Healthcare. 0% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare to precertify admission.
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.***
Healthy Pregnancies/Healthy Babies • *Care Management Outreach* • *Maternity Case Management* • *Neo-natal Case Management*	$200 (1st trimester) / $100 (2nd trimester)

Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law or covered under the pharmacy benefit:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under 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 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 review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section 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" section(s) of this plan.
    - Cosmetic surgery and therapies Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter 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.

  - 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, 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 and 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, or educational therapy.
- 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.
- 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.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.

- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- Massage therapy.
- Services and supplies that are not medically necessary as determined by the plan, however if a service is determined to be not medically necessary because it
  was not rendered in the least costly setting, covered expenses will be paid in an amount equal to the amount payable had the service been rendered in the least costly setting.
- Inpatient care and related physicians services rendered in conjunction with an Admission, which is principally for diagnostic studies or evaluative procedures
  that could have been performed on an outpatient basis are not covered unless the Covered Member’s medical condition alone required Admission.
- Unless such item, has a dollar or percentage amount associated with it on the Schedule of Medical Benefits, any services related to treatment of dysfunction of the muscles of mastication or orthognathic deformities.
- Prescription Drugs used for weight control, obesity, cosmetic purposes, hair growth, infertility or impotence (but not limited to fertility drugs), except as specifies on the Schedule of Medical Benefits.
- Travel, land lodging, whether or not recommended by a Physician, unless directly related to human organ or tissue transplants as specified on the Schedule of
- Medical Benefits and subject to pre-notification.
- Medical Supplies or services or changes for learning disabilities, developmental speech delay, perceptual disorders, mental retardation or vocational
- Rehabilitation, except as specified on the Schedule of Medical Benefits.
- Immunosuppressant drugs prescribed for an organ and/or tissue transplant. Applicable Benefits are payable under the human organ and tissue transplant benefit.
- Illness contracted or injury sustained as a result of participating in a riot or insurrection, or while engaged in the commission of a felony or an illegal occupation.
- All services, supplies, and prescription drugs related to direct termination of pregnancy.
- Prescription refills in excess of the number specified on the Physician’s prescription order or Prescription Drug refill dispensed more than 1 year after the original prescription date.
- Devices of any type, even though dispensed through a prescription, such as, but not limited to: contraceptive devices, therapeutic devices, artificial appliances or similar devices, other than Mirena IUD when there is a diagnosis of medical need. The device is covered under your pharmacy benefit, placement is covered under your medical benefit.
- Dosages that exceed the recommended daily dose of any Prescription Drug as described in the Physician’s Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower.
- Prescription Drugs for which there is an Over-the-Counter equivalent and over-the-counter supplies and supplements. Drugs that are available on an over-the- counter basis or otherwise available without a prescription, except as specified on the

Schedule of Medical Benefits.

- Prescription Drugs being prescribed for a specific medical condition that are not approved by the Food and Drug Administration for treatment of that condition except for Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that cancer in at least one standard, universally accept reference compendia or is found to be safe and effective in formal clinical studies, the rest of which have been published in peer-reviewed professional medical journals.
- Any Prescription Drug that is not consistent with diagnosis and treatment of a Covered Member's illness, injury or condition; or is excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
- Prescription Drugs that require pre-authorization and pre-authorization is not obtained by Cigna Pharmacy, as applicable.
- Prescription Drugs for injury or disease paid by Workers' Compensation Benefits (if a Workers' Compensation claim is settled, it will be considered paid by
  Workers' Compensation Benefits).
- Prescription Drugs that are not medically necessary.
- Unless different time frames are specifically listed on the Schedule of Medical Benefits, more than a thirty-one (31) day supply for Prescription Drugs, or ninety day supply for Prescription Drugs obtained through Mail Service Pharmacy or unless the quantity is limited by a QVT program.
- Prescription Drugs that are not authorized when a part of a Step Therapy Program.
- Medical Supplies, services or Prescription Drugs for treatment for smoking cessation, except as specified on the Schedule of Medical Benefits.
- Charges for Prescription Drugs that have not been prescribed by a Physician; Any vitamins except for prenatal vitamins; Prescription Drugs not approved by the
  Food and Drug Administration.
- Prescription Drugs for non-covered therapies, services, or conditions.
- Prescription Drugs administered, dispensed or brought at a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated.
- Charges for Prescription Drugs that are provided by a Physician but not consumed or administered in a physician's office.
- Fees for copying or production of medical records and/or claims filing.
- Charges for a covered member's appointment with a Provider that the covered member did not attend.
- Chronic pain management programs or multi-disciplinary pain management programs unless medically necessary.
- All Admissions solely for Physical Therapy, except as provided in the sections entitled "Definitions" for Rehabilitation Benefits.
- Charges for services, supplies or fees for pre-marital or pre-employment examinations.
- Charges for pre-operative anesthesia consultation.
- Medical Supplies or services or other items not specifically listed as a Benefit in the section entitled "Definitions" of this Plan, on the Schedule of Medical
- Benefits or as the law requires.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms o f coverage, exclusions and limitations, including legislated benefits, will be provided in your Group Service Agreement or Certificate.

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.

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.

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