

SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.
For - CraftWorks Holdings, Inc.
Open Access Plus HDHP 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 or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

| Plan Highlights | In-Network | Out-of-Network |
|--|---|---|
| Lifetime Maximum | Unlimited | Unlimited |
| Plan Coinsurance | Your plan pays 80% | Your plan pays 50% |
| Maximum Reimbursable Charge | Not Applicable | 110% |
| Contract Year Deductible | Individual - Employee Only: \$1,500 Individual - within a Family: \$2,800 Family Maximum: \$3,000 | Individual - Employee Only: \$3,000 Individual - within a Family: \$6,000 Family Maximum: \$6,000 |
| <ul style="list-style-type: none"> The amount you pay for all covered expenses counts towards both your in-network and out-of-network deductibles. Plan deductible always applies before any copay or coinsurance. Plan deductible does not apply to in-network preventive services. Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance. This plan includes a combined Medical/Pharmacy plan deductible. <p>Note: Services where plan deductible applies are noted with a caret (^).</p> | | |

| Plan Highlights | In-Network | Out-of-Network |
|--|---|--|
| <p>Contract Year Deductible</p> <ul style="list-style-type: none"> The amount you pay for all covered expenses counts towards both your in-network and out-of-network deductibles. Plan deductible always applies before any copay or coinsurance. After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan. This plan includes a combined Medical/Pharmacy plan deductible. <p>Note: Services where plan deductible applies are noted with a caret (^).</p> | Individual: \$1,500 Individual in a Family: \$3,000 Family: \$3,000 | Individual: \$3,000 Individual in a Family: \$6,000 Family: \$6,000 |
| <p>Contract Year Out-of-Pocket Maximum</p> <ul style="list-style-type: none"> The amount you pay for all covered expenses counts towards 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. After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. This plan includes a combined Medical/Pharmacy out-of-pocket maximum. | Individual - Employee Only: \$4,500 Individual - within a Family: \$4,500 Family Maximum: \$9,000 | Individual - Employee Only: \$9,000 Individual - within a Family: \$9,000 Family Maximum: \$18,000 |
| <p>Contract Year Out-of-Pocket Maximum</p> <ul style="list-style-type: none"> The amount you pay for all covered expenses counts towards 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. After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. This plan includes a combined Medical/Pharmacy out-of-pocket maximum. | Individual: \$4,500 Individual in a Family: \$4,500 Family: \$9,000 | Individual: \$9,000 Individual in a Family: \$9,000 Family: \$18,000 |
| Benefit | In-Network | Out-of-Network |
| Physician Services - Office Visits | | |
| Physician Office Visit – Primary Care Physician (PCP)/Specialist | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| Surgery Performed in Physician’s Office | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |

| Benefit | In-Network | Out-of-Network |
|---|--|--|
| Allergy Treatment/Injections Performed in Physician's Office | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Allergy Serum <ul style="list-style-type: none"> Dispensed by the physician in the office | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Cigna Telehealth Connection Services <ul style="list-style-type: none"> 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) | After the plan deductible is met, you pay \$40 copay | Not Covered |
| Preventive Care | | |
| Preventive Care <ul style="list-style-type: none"> 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. | Plan pays 100% | Not Covered |
| Immunizations | Plan pays 100% | Not Covered |
| Mammogram, PAP, and PSA Tests <ul style="list-style-type: none"> Coverage includes the associated Preventive Outpatient Professional Services. Associated wellness exam is covered in-network only. Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | Plan pays 100% | Coverage varies based on Place of Service |
| Inpatient | | |
| Inpatient Hospital Facility Services | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate | | |
| Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate | | |
| 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 | | |
| Inpatient Hospital Physician's Visit/Consultation | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Outpatient | | |
| Outpatient Facility Services | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |

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| Benefit | In-Network | Out-of-Network |
|---|--|--|
| Short-Term Rehabilitation Contract Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – 100 days Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Chiropractic Care Contract Year Maximum: <ul style="list-style-type: none"> Chiropractic Care - 24 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Other Health Care Facilities/Services | | |
| Home Health Care (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> 100 days maximum per Contract Year (The limit is not applicable to mental health and substance use disorder conditions.) 16 hour maximum per day | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities <ul style="list-style-type: none"> 120 days maximum per Contract Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Durable Medical Equipment <ul style="list-style-type: none"> Unlimited maximum per Contract Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Breast Feeding Equipment and Supplies <ul style="list-style-type: none"> Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies | Your plan pays 100% | Not Covered |
| External Prosthetic Appliances (EPA) <ul style="list-style-type: none"> Unlimited maximum per Contract Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Routine Foot Disorders Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary. | Not Covered | Not Covered |
| Acupuncture <ul style="list-style-type: none"> 24 days maximum per Contract Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Gender Reassignment Surgery <ul style="list-style-type: none"> Limited to 1 per Lifetime | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |

| Benefit | In-Network | Out-of-Network |
|--|--|--|
| Hearing Aid <ul style="list-style-type: none"> Unlimited dollar maximum per 36 months Maximum of 2 devices per 36 months Includes testing and fitting of hearing aid devices at Physician Office Visit cost share. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Wigs <ul style="list-style-type: none"> Unlimited maximum per Contract Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 80% |
| Medical Specialty Drugs | | |
| Inpatient <ul style="list-style-type: none"> 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. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Outpatient Facility Services <ul style="list-style-type: none"> 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. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Physician's Office <ul style="list-style-type: none"> 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. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |
| Home <ul style="list-style-type: none"> 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. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 50% |

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

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

| Benefit | Physician's Office | | Independent Lab | | Emergency Room/ Urgent Care Facility | | Outpatient Facility | |
|-------------------|--|--|--------------------|--------------------|--|--|---------------------|--------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Laboratory | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Plan pays 80% ^ | Plan pays 50% ^ | Covered same as plan's Emergency Room/Urgent Care Services | Covered same as plan's Emergency Room/Urgent Care Services | Plan pays 80% ^ | Plan pays 50% ^ |

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

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

| Benefit | Physician's Office | | Independent Lab | | Emergency Room/ Urgent Care Facility | | Outpatient Facility | |
|-----------------------------------|--|--|-----------------|----------------|--|--|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Radiology | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Not Applicable | Not Applicable | Covered same as plan's Emergency Room/Urgent Care Services | Covered same as plan's Emergency Room/Urgent Care Services | Plan pays 80% ^ | Plan pays 50% ^ |
| Advanced Radiology Imaging | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Not Applicable | Not Applicable | Covered same as plan's Emergency Room/Urgent Care Services | Covered same as plan's Emergency Room/Urgent Care Services | Covered same as plan's Outpatient Facility Services | Covered same as plan's Outpatient Facility Services |

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

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

| Benefit | Emergency Room / Urgent Care Facility | | Outpatient Professional Services | | *Ambulance | |
|-----------------------|--|----------------------------|----------------------------------|----------------------------|----------------------------|----------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Emergency Care | <u>Life-Threatening Conditions:</u> After the plan deductible is met, \$150 per visit copay (copay waived if admitted), then your plan pays 100% <u>Non Life-Threatening Conditions:</u> After the plan deductible is met, \$300 per visit copay (copay waived if admitted), then your plan pays 100% | | Plan pays 100% | | Plan pays 80% [^] | |
| Urgent Care | Plan pays 80% [^] | Plan pays 50% [^] | Plan pays 80% [^] | Plan pays 50% [^] | Not Applicable* | |

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

| Benefit | Inpatient Hospital and Other Health Care Facilities | | Outpatient Services | |
|-------------------------------|---|----------------------------|----------------------------|----------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Hospice | Plan pays 80% [^] | Plan pays 50% [^] | Plan pays 80% [^] | Plan pays 50% [^] |
| Bereavement Counseling | Plan pays 80% [^] | Plan pays 50% [^] | Plan pays 80% [^] | Plan pays 50% [^] |

Note: Services provided as part of Hospice Care Program

| Benefit | Initial Visit to Confirm Pregnancy | | Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges) | | Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist) | | Delivery - Facility (Inpatient Hospital, Birthing Center) | | | |
|---|--|--|---|--------------------|---|--|---|--|---|---|
| | In-Network | Out-of- Network | In-Network | Out-of- Network | In-Network | Out-of- Network | In-Network | Out-of- Network | | |
| Maternity | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Plan pays 80% ^ | Plan pays 50% ^ | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit | | |
| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
| | In-Network | Out-of- Network | In-Network | Out-of- Network | In-Network | Out-of- Network | In-Network | Out-of- Network | In-Network | Out-of- Network |
| Abortion (Non-elective procedures) | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Covered same as plan's Inpatient Professional Services | Covered same as plan's Inpatient Professional Services | Covered same as plan's Outpatient Professional Services | Covered same as plan's Outpatient Professional Services |
| 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 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Covered same as plan's Inpatient Professional Services | Covered same as plan's Inpatient Professional Services | Covered same as plan's Outpatient Professional Services | Covered same as plan's Outpatient Professional Services |
| Includes surgical services, such as vasectomy (excludes reversals) | | | | | | | | | | |
| Family Planning - Women's Services | Plan pays 100% | Covered same as plan's Physician's Office Services | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Plan pays 50% ^ | Plan pays 100% | Covered same as plan's Inpatient Professional Services | Plan pays 100% | Covered same as plan's Outpatient Professional Services |
| Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician. | | | | | | | | | | |
| Infertility - Coverage for Infertility Services are provided by Progyny. | | | | | | | | | | |

| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
|---------------------------------------|--|--|--------------------|-----------------|---------------------|-----------------|--|--|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| TMJ, Surgical and Non-Surgical | Covered same as plan's Physician's Office Services | Covered same as plan's Physician's Office Services | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Covered same as plan's Inpatient Professional Services | Covered same as plan's Inpatient Professional Services | Covered same as plan's Outpatient Professional Services | Covered same as plan's Outpatient Professional Services |

Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime

| Benefit | Inpatient Hospital Facility | | | Inpatient Professional Services | | |
|--|--|------------------------------------|----------------|--|------------------------------------|----------------|
| | Cigna LifeSOURCE Transplant Network® Facility In-Network | Non-LifeSOURCE Facility In-Network | Out-of-Network | Cigna LifeSOURCE Transplant Network® Facility In-Network | Non-LifeSOURCE Facility In-Network | Out-of-Network |
| Organ Transplants Coverage at Lifesource Facilities only. | Plan pays 100% ^ | Not Covered | Not Covered | Plan pays 100% ^ | Not Covered | Not Covered |

- Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: \$10,000 maximum per Transplant

| Benefit | Inpatient | | Outpatient - Physician's Office | | Outpatient – All Other Services | |
|-------------------------------|-----------------|-----------------|---------------------------------|-----------------|---------------------------------|-----------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Mental Health | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |
| Substance Use Disorder | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ | Plan pays 80% ^ | Plan pays 50% ^ |

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

Notes:

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

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
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy

Please see Summary of Benefits and Coverage (SBC) for information on pharmacy benefits.

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.

Cigna Diabetes Prevention Program in collaboration with Omada

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

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

Additional Information

Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

Multiple Surgical Reduction

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

One Guide

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

Additional Information

Pre-Certification - Continued Stay Review – Basic Care Standard Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- \$750 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Basic Care Standard Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

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

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

Definitions

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

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

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

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

Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

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

Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

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

Exclusions

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

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or

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Exclusions

Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
 - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
 - o 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;
 - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
 - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
- In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services.
- Reversal of male or female voluntary sterilization procedures.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.

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Exclusions

- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications 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.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

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These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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