SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - City of Dallas
70/30 Plan - Open Access Plus IN

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
Lifetime Maximum	Unlimited
Coinsurance	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable
Calendar Year Deductible	Individual: $3,000 Family: $9,000

- Copays always apply before plan deductible and 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.

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

Calendar Year Out-of-Pocket Maximum	Individual: $6,350 Family: $12,700

- Plan deductible contributes 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.

Benefit	In-Network
Physician Services	
Physician Office Visit – Primary Care Physician (PCP) • All services including Lab & X-ray	After the plan deductible is met, your plan pays 70%

Benefit	In-Network
Physician Office Visit – Specialist • All services including Lab & X-ray	After the plan deductible is met, your plan pays 70%
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 - PCP	After the plan deductible is met, your plan pays 70%
Surgery Performed in Physician's Office – Specialist	After the plan deductible is met, your plan pays 70%
Allergy Treatment/Injections Performed in Physician's Office PCP	After the plan deductible is met, your plan pays 70%
Allergy Treatment/Injections Performed in Specialist Office	After the plan deductible is met, your plan pays 70%
Allergy Serum - PCP	After the plan deductible is met, your plan pays 70%
Allergy Serum - Specialist	After the plan deductible is met, your plan pays 70%
• Dispensed by the physician in the office	
Preventive Care	
Preventive Care • 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%
Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	
Inpatient	
Inpatient Hospital Facility	After the plan deductible is met, your plan pays 70% *90% after you meet the Annual Deductible if you utilize either Baylor or Methodist Hospitals in Dallas/Fort Worth.This applies to facility charges only. All other charges (physician fees, lab services, etc.) are paid at 70%, after you meet your Annual Deductible.*
Semi-Private Room: Limited to the semi-private negotiated rate **Private Room:** Limited to the semi-private negotiated rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to the negotiated rate	

Benefit	In-Network
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 70%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 70%
Outpatient	
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	After the plan deductible is met, your plan pays 70% *90% after you meet the Annual Deductible if you utilize either Baylor or Methodist Hospitals in Dallas/Fort Worth.This applies to facility charges only. All other charges (physician fees, lab services, etc.) are paid at 70%, after you meet your Annual Deductible.*
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 70%
Short-Term Rehabilitation – PCP or Specialist Calendar Year Maximums: • Pulmonary Rehabilitation - 20 days • Cognitive Therapy - 20 days • Chiropractic Care - 20 days • Physical Therapy - 20 days • Occupational Therapy - 20 days • Speech Therapy - 50 days • Cardiac Rehabilitation - 36 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 70%
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year	After the plan deductible is met, your plan pays 70%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 120 days maximum per Calendar Year	After the plan deductible is met, your plan pays 70%
Durable Medical Equipment • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 70%

Benefit	In-Network
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	After the plan deductible is met, your plan pays 70%
Routine Foot Disorders	Not Covered
Wigs Benefits are limited to $300 per calendar year. The Plan pays benefits for wigs and other scalp hair prosthesis when prescribed for hair loss due to a medical condition, chemotherapy or radiation.	After the plan deductible is met, your plan pays 70%
Acupuncture • Unlimited days maximum per Calendar Year	After the plan deductible is met, your plan pays 70%
Medical Specialty Drugs	
Inpatient • 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 70%
Outpatient Facility Services • 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 70%
Physician's Office • This benefit applies to the cost of the 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 70%
Home • This benefit applies to the cost of the 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 70%

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	In-Network	In-Network	In-Network
Laboratory	Covered same as plan's Physician's Office Services	Plan pays 70% ^	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 70% ^
Radiology	Covered same as plan's Physician's Office Services	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 70% ^
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Not Applicable	Covered same as plan's Emergency Room/Urgent Care 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	In-Network	In-Network
Emergency Care	$250 per visit (copay waived if admitted) ^, then your plan pays 70%	Plan pays 70%^	Plan pays 70%^
Urgent Care	Plan pays 70%^ On Site Clinic - No charge Concentra Clinics (Dallas Metroplex area) - $25 per visit copay, then plan pays 100%	Plan pays 70%^	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	In-Network
Hospice	Plan pays 70% ^	Plan pays 70% ^
Bereavement Counseling	Plan pays 70% ^	Plan pays 70% ^

Note: Services provided as part of Hospice Care Program
Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	In-Network	In-Network	In-Network	In-Network
Maternity	Covered same as plan's Physician's Office Services	Plan pays 70% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit

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

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
Abortion (Non-elective procedures)	Covered same as plan's Physician's Office Services	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
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	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^
Surgeon Charges Lifetime Maximum: $5,000					
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					
Note: Services where plan deductible applies are noted with a caret (^)					

Benefit	Inpatient Hospital Facility		Inpatient Professional Services	
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network
Organ Transplants	Plan pays 90% ^	Plan pays 70% ^ *90% after you meet the Annual Deductible if you utilize either Baylor or Methodist Hospitals in Dallas/Fort Worth. This applies to facility charges only. All other charges (physician fees, lab services, etc.) are paid at 70%, after you meet your Annual Deductible.*	Plan pays 90% ^	Plan pays 70% ^

- Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime

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

Benefit	Inpatient	Outpatient - Physician's Office	Outpatient – All Other Services
	In-Network	In-Network	In-Network
Mental Health	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^
Substance Use Disorder	Plan pays 70% ^	Plan pays 70% ^	Plan pays 70% ^

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

Notes: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum
- Inpatient includes Residential Treatment
- Outpatient includes Individual, Intensive Outpatient, 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
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy

Pharmacy benefits not provided by Cigna

Additional Information

Case Management
Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

eVisits
Provides an online consultation service, or “eVisit,” with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay a predetermined copay or coinsurance based on their benefit plan design. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

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

Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In Network: Coordinated by your physician

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

Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under

Exclusions

this plan. 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.

- Charges arising out of or related 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 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; 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.
- 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

Exclusions

(GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling in preparation for, or subsequent to, any such surgery. Hormonal therapy may be covered through Pharmacy benefits provided by CVS Caremark.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- 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.
- 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.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

Exclusions

- 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 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.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

EHB State: TX

City of Dallas: Open Access Plus IN 70/30

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | **Plan Type:** OAP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/sp/ or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$3,000** person / **$9,000** family Does not apply to in-network preventive care & immunizations Co-payments don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. This plan includes a separate Pharmacy **Deductible**.	You do have to meet a separate pharmacy **deductible.** You don't have to meet **deductibles** for any other specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$6,350** person / **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-insurance/visit	Not Covered	----------none----------
	Specialist visit	30% co-insurance/visit	Not Covered	----------none----------
	Other practitioner office visit	For acupuncture: 30% co-insurance/visit For chiropractor: Specialist: 30% co-insurance/visit	Not Covered	Coverage for chiropractic care and rehabilitation services is limited to 20 visits annual max and for acupuncture 20 visits annual max.
	Preventive care/screening/ immunization	No charge/visit No charge/screening No charge/ immunizations	Not Covered	----------none---------- ----------none---------- ----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	30% co-insurance	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition Your prescription drug coverage is available through **CVS/Caremark**. More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	10% ($10 min) / prescription (retail), 10% ($10 min) / prescription (mail order)	Not Covered	Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (mail order)
	Preferred brand drugs	25% ($25 min) / prescription (retail), 25% ($25 min) / prescription (mail order)	Not Covered	Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (mail order)
	Non-preferred brand drugs	40% ($40 min)/ prescription (retail), 40% ($40 min)/ prescription (mail order)	Not Covered	Coverage is limited up to a 31-day supply (retail) and up to a 90-day supply (mail order)
	Specialty drugs	Specialty drug formulary prescriptions must be filled with a drug on CVS/Caremark's approved list.	Not Covered	Specialty drugs on the "excluded" list will be full cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance, 10% coinsurance if you utilize either Baylor or Methodist Hospitals in Dallas/Fort Worth (applies to facility charges only)	Not Covered	----------none----------
	Physician/surgeon fees	30% co-insurance	Not Covered	----------none----------
If you need immediate medical attention	Emergency room services	$250 co-pay/visit, then plan deductible, then 30% coinsurance	$250 co-pay/visit, then plan deductible, then 30% coinsurance	Per visit co-pay is waived if admitted
	Emergency medical transportation	30% co-insurance	30% co-insurance	----------none----------
	Urgent care	30% co-insurance, On Site Clinic - No charge Concentra Clinics (Dallas Metroplex area) - $35 per visit copay, then plan pays 100%, deductible is waived	30% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance, 10% coinsurance if you utilize either Baylor or Methodist Hospitals in Dallas/Fort Worth (applies to facility charges only)	Not Covered	----------none----------
	Physician/surgeon fees	30% co-insurance	Not Covered	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance/office visit 30% co-insurance/all other services	Not Covered	----------none----------
	Mental/Behavioral health inpatient services	30% co-insurance	Not Covered	----------none----------
	Substance use disorder outpatient services	30% co-insurance/office visit 30% co-insurance/all other services	Not Covered	----------none----------
	Substance use disorder inpatient services	30% co-insurance	Not Covered	----------none----------
If you are pregnant	Prenatal and postnatal care	30% co-insurance	Not Covered	----------none----------
	Delivery and all inpatient services	30% co-insurance	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	Not Covered	----------none----------
	Rehabilitation services	30% co-insurance/PCP visit 30% co-insurance/Specialist visit	Not Covered	Coverage is limited to annual max of: 20 days each for Pulmonary rehab, Cognitive therapy, Chiropractic care services, Physical therapy, and Occupational therapy; 50 days for Speech therapy; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	30% co-insurance	Not Covered	Coverage is limited to 120 days annual max.
	Durable medical equipment	30% co-insurance	Not Covered	----------none----------
	Hospice services	30% co-insurance/inpatient; 30% co-insurance/outpatient services	Not Covered	----------none----------
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,090
- **Patient pays:** $4,450

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$3,000
Co-pays	$0
Co-insurance	$1,420
Limits or exclusions	$30
Total	**$4,450**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $90
- **Patient pays:** $5,310

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$990
Co-pays	$0
Co-insurance	$4,040
Limits or exclusions	$280
Total	**$5,310**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 5632627 **BenefitVersion:** 7
Plan Name: 70/30 Plan - OAPIN