SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Trustees of Dartmouth College
Open Access Plus Plan

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

CareLinkSM Features
Access to the Open Access Plus/CareLinkSM network of participating providers, which consists of:
- Tufts Health Plan providers in Massachusetts and Rhode Island
- Cigna HealthCare Open Access Plus providers in all other states
- The network includes many of the doctors, hospitals, and other facilities in your area. All participating providers have met credentialing requirements
- Cigna Behavioral Care Network for Mental Health and Substance Use Disorder nationwide

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td>Coinsurance</td>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
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<tr>
<td>Maximum Reimbursable Charge</td>
<td>Not Applicable</td>
<td>200%</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>Individual: $2,600</td>
<td>Individual: $4,100</td>
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<td>Family: $5,200</td>
<td>Family: $8,200</td>
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</tbody>
</table>

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- 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.

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

<table>
<thead>
<tr>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Individual: $4,000</td>
<td>Individual: $6,500</td>
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<tr>
<td>Family: $8,000</td>
<td>Family: $13,000</td>
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</table>

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All 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.

### In-Network

## Physician Services

### Physician Office Visit
- All services including Lab & X-ray
  - Your plan pays 90% ^

### Surgery Performed in Physician's Office
- Your plan pays 90% ^

### Allergy Treatment/Injections
- Your plan pays 90% ^

### Allergy Serum
- Dispensed by the physician in the office
  - Your plan pays 90% ^

## Preventive Care

### Preventive Care
- Your plan pays 100%
  - Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.

### Immunizations
- Includes travel and rabies immunizations
  - Your plan pays 100%

### Mammogram, PAP, and PSA Tests
  - Your 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
  - Your plan pays 90% ^

### 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
  - Your plan pays 90% ^

### Inpatient Professional Services
  - For services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists
    - Your plan pays 90% ^
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
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</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
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<tr>
<td>Outpatient Facility Services</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</td>
<td></td>
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<tr>
<td><strong>Short-Term Rehabilitation</strong></td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>Per Calendar Year Maximums:</td>
<td></td>
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<tr>
<td>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy - 80 days</td>
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<tr>
<td>• Cardiac Rehabilitation - 36 days</td>
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<td>• Chiropractic Care - 20 days</td>
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<tr>
<td>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</td>
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<tr>
<td>Note: For physical/speech/occupational therapy services, medical necessity review will take place after your 25th visit. Speech, physical, and/or occupational therapy for autism spectrum disorder is covered on an unlimited basis.</td>
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<tr>
<td><strong>Other Health Care Facilities/Services</strong></td>
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<tr>
<td>Home Health Care (includes outpatient private duty nursing subject to medical necessity)</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited days maximum per Calendar Year</td>
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<tr>
<td>• 16 hour maximum per day</td>
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<tr>
<td>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
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<tr>
<td>• Combined 100 days per Calendar Year for Rehabilitation hospital and other facilities</td>
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<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited maximum per Calendar Year</td>
<td></td>
<td></td>
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<tr>
<td><strong>Breast Feeding Equipment and Supplies</strong></td>
<td>Your plan pays 100%</td>
<td>Your plan pays 70% ^</td>
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<tr>
<td>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</td>
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<tr>
<td>• Includes related supplies</td>
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<tr>
<td>External Prosthetic Appliances (EPA)</td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited maximum per Calendar Year</td>
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<tr>
<td>Routine Foot Disorders</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.</td>
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<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
</tr>
<tr>
<td>• Unlimited maximum per Calendar Year</td>
<td></td>
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<tr>
<td><strong>Nutritional Supplements</strong></td>
<td>Your plan pays 90% ^</td>
<td>Your plan pays 70% ^</td>
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<tr>
<td>• Includes special medical formulas regardless of the diagnosis</td>
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<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<td>--------------------------------------------------</td>
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<tr>
<td><strong>Routine Hearing Exam</strong></td>
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<tr>
<td>Limited to 1 hearing exam per Calendar Year</td>
<td>Your plan pays 100%</td>
<td>Your plan pays 70%</td>
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<tr>
<td><strong>Hearing Aid</strong></td>
<td></td>
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<tr>
<td>Age 19 and over - $3,000 maximum per Calendar Year</td>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
</tr>
<tr>
<td>Age 18 and under - Unlimited maximum per Calendar Year</td>
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<tr>
<td>Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level</td>
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<tr>
<td><strong>Oral Surgery - Impacted Wisdom Teeth Inpatient Facility</strong></td>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
</tr>
<tr>
<td>Includes coverage for surgical removal of boney impacted teeth in office or hospital setting.</td>
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<tr>
<td><strong>Weight Management Classes</strong></td>
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<tr>
<td>Limited to S9449</td>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
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<tr>
<td><strong>Wigs</strong></td>
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<tr>
<td>Unlimited maximum per Calendar Year</td>
<td>Your plan pays 90%</td>
<td>Your plan pays 70%</td>
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</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician's Office</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Independent Lab</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Emergency Room/ Urgent Care Facility</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
</tr>
</tbody>
</table>

**Lab and X-ray**
- 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

**Advanced Radiology Imaging**
- Plan pays 90% ^
- Plan pays 70% ^

**Benefit**
- Emergency Room/ Urgent Care Facility
  - In-Network: Plan pays 90% ^
  - Out-of-Network: Plan pays 70% ^
- Outpatient Professional Services
  - In-Network: Plan pays 90% ^
  - Out-of-Network: Plan pays 70% ^
- Ambulance
  - In-Network: Plan pays 90% ^
  - Out-of-Network: 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
  - In-Network: Plan pays 90% ^
  - Out-of-Network: Plan pays 70% ^
- Outpatient Services
  - In-Network: Plan pays 90% ^
  - Out-of-Network: Plan pays 70% ^

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<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Inpatient Hospital and Other Health Care Facilities</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement Counseling</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
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</table>
| Note: Services provided as part of Hospice Care Program
Note: Services where plan deductible applies are noted with a caret (^) |

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Inpatient Hospital and Other Health Care Facilities</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
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<td>Note: Services where plan deductible applies are noted with a caret (^)</td>
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<tr>
<td>Abortion</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
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<td>Family</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
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<td>Planning - Men's Services</td>
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<td>Family</td>
<td>Plan pays 100%</td>
<td>Plan pays 70%</td>
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<td>Planning - Women's Services</td>
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<tr>
<td>Infertility</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
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<tr>
<td>TMJ, Surgical and Non-Surgical</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
<td>Plan pays 70%</td>
<td>Plan pays 90%</td>
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Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.
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**

**Non-Surgical: Unlimited maximum per lifetime**

**Bariatric Surgery**
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^

**Surgeon Charges Lifetime Maximum:** Unlimited

Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered.

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

**Organ Transplants**
- Plan pays 100%
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 100%
- Plan pays 90% ^
- Plan pays 70% ^

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

**Mental Health**
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- First 12 visits per Lifetime, Plan pays 90%, no copay, no plan deductible; 13th visit and after, Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^

**Substance Use Disorder**
- Plan pays 90% ^
- Plan pays 70% ^
- Plan pays 90% ^
- First 12 visits per Lifetime, Plan pays 90%, no copay, no plan deductible; 13th visit and after, Plan pays 70% ^
- Plan pays 90% ^
- Plan pays 70% ^

Note: Services where plan deductible applies are noted with a caret (^)
Note: 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 partial hospitalization and individual, intensive outpatient and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs
Cigna Behavioral Advantage - Inpatient and Outpatient Management
- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy
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.

Maximum Reimbursable Charge
Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (200%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

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.
### Additional Information

**Personal Health Team - A**  
Client specific team of clinical specialists who provide support for healthy, at-risk and acute care individuals to help them stay healthy

- Health and Wellness Coaching  
- Cigna Well Informed Program  
- Preference Sensitive Care  
- Behavioral Health Case Management  
- 24 hour Health Information Line Outreach  
- Pre Admission Outreach  
- Post Discharge Outreach  
- Inpatient Advocacy  
- Case Management - Short term and complex care facility - Pittsburgh  
- Team Number - 462

**Pre-Certification - Continued Stay Review - PHS+ Inpatient** - required for all inpatient admissions  
In Network: Coordinated by your physician  
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.  
- $500 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 - Continued Stay Review - PHS+ Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing  
In Network: Coordinated by your physician  
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.  
- $500 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.  
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

**Pre-Existing Condition Limitation (PCL)** does not apply.
### Additional Information

#### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

#### Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

### Definitions

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

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

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

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

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

**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.
Exclusions

- 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.
- 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.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; 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 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

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 mental retardation.
- 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.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
### Exclusions

- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs.
- 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.
- 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.

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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 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.

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