

SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

City of Centennial
LocalPlus IN
Effective 1/1/2017



General Services	In-Network	
Physician office visit – Primary Care Physician (PCP)	You pay \$20 per visit copay, then plan pays 100%	
Physician Office Visit – Specialist	You pay \$40 per visit copay, then plan pays 100%	
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). 	You pay \$5 per visit copay, then plan pays 100%	
Urgent care visit <ul style="list-style-type: none"> All services including Lab & X-ray 	You pay \$50 per visit copay, then plan pays 100%	
Preventive Care	Plan pays 100%, no copay, no deductible	
Preventive Services	Plan pays 100%, no copay, no deductible	
Immunizations	Plan pays 100%, no copay, no deductible	
Pharmacy Coverage	In-Network	Out-of-Network
Performance pharmacy plan <ul style="list-style-type: none"> Includes contraceptives If a Brand name drug is requested when there is a Generic equivalent, member must purchase the Generic drug, or pay 100% of the difference between the Brand name price and the Generic price, plus the appropriate brand-name copay (unless the physician indicates "Dispense As Written" DAW) Pharmacy Network - Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan. Specialty medications are limited to a 30-day supply 	Retail - (per 30 day supply) Tier 1: \$10 Tier 2: \$20 Tier 3: \$60 Retail and Home Delivery - (per 90 day supply) Tier 1: \$30 Tier 2: \$60 Tier 3: \$180	In-network coverage only
Coinsurance	After the plan deductible is met, You pay 10% Plan pays 90%	

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General Services	In-Network
Calendar year deductible <ul style="list-style-type: none"> Benefits for an individual within a family are paid once the individual deductible has been met. Copays always apply before plan deductible and coinsurance. 	Individual: \$750 Family: \$1,500
Out-of-pocket annual maximum <ul style="list-style-type: none"> Medical copays apply towards the out-of-pocket maximums Medical deductibles apply towards the out-of-pocket maximums Pharmacy copays and coinsurance apply towards the out-of-pocket maximums 	Individual: \$2,500 Family: \$6,250
Lifetime maximum	Unlimited Per individual
Emergency room care <ul style="list-style-type: none"> All services rendered apply to ER benefit including Lab & X-ray 	You pay \$300 per visit copay (waived if admitted), then plan pays 100%
Ambulance	After the plan deductible is met, You pay 10% Plan pays 90%
Office surgery – PCP	After the plan deductible is met, You pay 10% Plan pays 90%
Office surgery – Specialist	After the plan deductible is met, You pay 10% Plan pays 90%
Other office services – laboratory	Covered same as plan's Physician's Office Services
Other office services – radiology	Covered same as plan's Physician's Office Services
Outpatient lab	Plan pays 100%, no deductible
Outpatient radiology	Plan pays 100%, no deductible
Independent lab	Plan pays 100%, no deductible
Office advanced radiology imaging services <ul style="list-style-type: none"> Includes MRI, MRA, PET, CT-Scan and Nuclear medicine 	After the plan deductible is met, You pay 10% Plan pays 90%
Outpatient advanced radiology imaging services <ul style="list-style-type: none"> Includes MRI, MRA, PET, CT-Scan and Nuclear medicine 	After the plan deductible is met, You pay 10% Plan pays 90%
Durable medical equipment <ul style="list-style-type: none"> Includes external prosthetic appliances Does accumulate towards the out-of-pocket maximum 	After the plan deductible is met, You pay 10% Plan pays 90%
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 	Plan pays 100%, no copay, no deductible

Benefits	In-Network
Hospital Services	

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Benefits	In-Network
Inpatient hospital services	After the plan deductible is met, You pay 10% Plan pays 90%
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician 	After the plan deductible is met, You pay 10% Plan pays 90%
Outpatient hospital services	After the plan deductible is met, You pay 10% Plan pays 90%
Outpatient professional services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists 	After the plan deductible is met, You pay 10% Plan pays 90%
Skilled nursing facility care <ul style="list-style-type: none"> 60 days per calendar year maximum 	After the plan deductible is met, You pay 10% Plan pays 90%
Hospice care	After the plan deductible is met, You pay 10% Plan pays 90%
Home health care <ul style="list-style-type: none"> 60 visits per calendar year maximum 	After the plan deductible is met, You pay 10% Plan pays 90%
Mental Health and Substance Use Disorder	
Inpatient mental health <ul style="list-style-type: none"> Includes Residential Treatment 	After the plan deductible is met, You pay 10% Plan pays 90%
Outpatient mental health – Physician’s Office <ul style="list-style-type: none"> Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy 	You pay \$40 copay
Outpatient mental health – all other services <ul style="list-style-type: none"> Includes Partial Hospitalization Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy 	After the plan deductible is met, You pay 10% Plan pays 90%
Inpatient substance use disorder <ul style="list-style-type: none"> Includes Residential Treatment 	After the plan deductible is met, You pay 10% Plan pays 90%
Outpatient substance use disorder – Physician’s Office <ul style="list-style-type: none"> Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy 	You pay \$40 copay
Outpatient substance use disorder – all other services <ul style="list-style-type: none"> Includes Partial Hospitalization Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy 	After the plan deductible is met, You pay 10% Plan pays 90%
Therapy Services	
Outpatient physical therapy <ul style="list-style-type: none"> 20 visits per calendar year 	Covered same as plan's Physician Office Visit – Specialist

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Benefits	In-Network
Outpatient speech therapy, hearing therapy and occupational therapy <ul style="list-style-type: none"> 20 visits per calendar year 	Covered same as plan's Physician Office Visit – Specialist
Chiropractic services	Covered same as Specialist's Office Visit
Acupuncture	Not Covered
Additional Services	
Medical Specialty Drugs Inpatient Facility <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, You pay 10% Plan pays 90%
Medical Specialty Drugs Outpatient Facility <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, You pay 10% Plan pays 90%
Medical Specialty Drugs 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, You pay 10% Plan pays 90%
Medical Specialty Drugs 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, You pay 10% Plan pays 90%
PPACA Women's Health <ul style="list-style-type: none"> Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices are included. 	Plan pays 100%, no copay, no deductible
Family planning <ul style="list-style-type: none"> Includes surgical services, such as vasectomy (excludes reversals) 	Varies based on place of service
Infertility	Not Covered
Abortion <ul style="list-style-type: none"> Includes non-elective procedures only 	Varies based on place of service
TMJ	Not Covered
Organ transplant <ul style="list-style-type: none"> Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities Travel maximum \$10,000 per transplant (only available if using Cigna LifeSOURCE Transplant Network® facility) 	After the plan deductible is met, You pay 10% Plan pays 90%

Benefits	In-Network
<p>Out-of-area services</p> <ul style="list-style-type: none"> • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • In-network deductible and out-of-pocket maximums apply 	<p>For all other services You pay 20% Plan pays 80% after the plan deductible is met</p>

Additional Information

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.

Out of Pocket Maximum

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards out-of-pocket maximums
- Deductibles apply towards out-of-pocket maximums

Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their clients.

General Notice of Preexisting Condition Exclusion

- Not applicable

Exclusions

What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

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.

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