

SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.
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.

Plan Highlights

| | | |
|--|---------------|---------------|
| Lifetime Maximum | Plan Specific | Plan Specific |
| Coinsurance | Plan Specific | Plan Specific |
| Maximum Reimbursable Charge | Plan Specific | Plan Specific |
| Calendar Year Deductible | Plan Specific | Plan Specific |
| <ul style="list-style-type: none"> Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network 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. | | |
| Calendar Year Out-of-Pocket Maximum | Plan Specific | Plan Specific |
| <ul style="list-style-type: none"> Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network 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 copays and benefit deductibles contribute towards your out-of-pocket maximum. Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum. After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. | | |

3/1/2017

WA

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Benefit

Physician Services

| | | |
|--|---------------|---------------|
| Physician Office Visit <ul style="list-style-type: none"> All services including Lab & X-ray | Plan Specific | Plan Specific |
| Surgery Performed in Physician's Office | Plan Specific | Plan Specific |
| Allergy Treatment/Injections | Plan Specific | Plan Specific |
| Allergy Serum Dispensed by the physician in the office | Plan Specific | Plan Specific |
| 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). Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person. | Plan Specific | Plan Specific |

Preventive Care

| | | |
|--|---------------|---------------|
| Preventive Care <ul style="list-style-type: none"> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. | Plan Specific | Plan Specific |
| Immunizations | Plan Specific | Plan Specific |
| Mammogram, PAP, and PSA Tests <ul style="list-style-type: none"> 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. | Plan Specific | Plan Specific |

Inpatient

| | | |
|---|---------------|---------------|
| Inpatient Hospital Facility | Plan Specific | Plan Specific |
| 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 | Plan Specific | Plan Specific |
| Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan Specific | Plan Specific |

Outpatient

| | | |
|---|---------------|---------------|
| Outpatient Facility Services <ul style="list-style-type: none"> Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible | Plan Specific | Plan Specific |
| Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan Specific | Plan Specific |

3/1/2017

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Benefit

Short-Term Rehabilitation

Plan Specific

Plan Specific

Other Health Care Facilities/Services

Home Health Care

(includes outpatient private duty nursing subject to medical necessity)

Plan Specific

Plan Specific

Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility

Plan Specific

Plan Specific

Durable Medical Equipment

- Unlimited maximum per Calendar Year

Plan Specific

Plan Specific

Breast Feeding Equipment and Supplies

Plan Specific

Plan Specific

External Prosthetic Appliances (EPA)

Plan Specific

Plan Specific

Routine Foot Disorders

Not Covered

Not Covered

Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

| Benefit | Physician's Office | | Independent Lab | | Emergency Room/ Urgent Care Facility | | Outpatient Facility | |
|-----------------------------------|--------------------|---------------|-----------------|---------------|--------------------------------------|---------------|---------------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Lab and X-ray | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Advanced Radiology Imaging | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

3/1/2017

WA

Open Access Plus - Coinsurance - WA OAP - Coinsurance Plan - 5780714. Version# 8

| Benefit | Emergency Room / Urgent Care Facility | | Outpatient Professional Services | | Ambulance | |
|-----------------------|---------------------------------------|---------------|----------------------------------|---------------|---------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Emergency Care | Plan Specific | | Plan Specific | | Plan Specific | |
| Urgent Care | Plan Specific | | Plan Specific | | Plan Specific | |

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 | | |
|-------------------------------|---|---------------|---------------|---------------------|---------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Hospice | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Bereavement Counseling | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

| 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) | |
|------------------|------------------------------------|---------------|--|---------------|---|---------------|---|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Maternity | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
|---|--------------------|---------------|--------------------|---------------|---------------------|---------------|---------------------------------|---------------|----------------------------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Abortion (Non-elective procedures) | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Family Planning - Men's Services | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

Includes surgical services, such as vasectomy (excludes reversals)

| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
|---|--------------------|---------------|--------------------|---------------|---------------------|---------------|---------------------------------|---------------|----------------------------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Family Planning - Women's Services | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

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.

| Benefit | Inpatient Hospital Facility | | | Inpatient Professional Services | | |
|--------------------------|-----------------------------|---------------|---------------|---------------------------------|---------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Organ Transplants | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

| Benefit | Inpatient | | Outpatient - Physician's Office | | Outpatient – All Other Services | |
|-------------------------------|---------------|---------------|---------------------------------|---------------|---------------------------------|---------------|
| | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Mental Health | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |
| Substance Use Disorder | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific | Plan Specific |

Note: Detox is covered under medical

- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

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

Cigna Pharmacy Plus three-tier coinsurance plan

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- When patient requests brand drug, patient pays the generic coinsurance plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- Self Administered injectable drugs - excludes infertility drugs
- Oral contraceptives included
- Includes oral contraceptives
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included
- Specialty medications are limited to a 30-day supply

Plan Specific

Plan Specific

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
 - o Benefits Exclusion - prior authorization, age edits and quantity over time edits.
 - o Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
 - o Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.

3/1/2017

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Pharmacy Program Information

Prescription Drug List:

- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Specialty Pharmacy Management:

- Clinical Programs
 - Prior authorization is required on specialty medications but quantity limits may apply.
 - Theracare® Program
- Medication Access Option
 - Retail and/or Home Delivery

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

High Blood Pressure (ACEI/ARB), Cholesterol Lowering (STATIN), Heartburn/Ulcer (PPI), Bladder Problems (OAB), Osteoporosis (Bone), Non-Narcotic Pain relievers (NSAID), ADD/ADHD (ADHD), Allergy (Nasal Steroids), Depression (SSRI/SNRI)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

Sleep Disorders (HYPNOTICS), Mental Health (ATYPICAL PSYCHS), Asthma (ASTHMA)

- Generic or PB First One Step – Step 1 (Generic) or Step 2 (Preferred Brand) medications must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

Skin Conditions (TI), Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 60 days grace period
- First Fill Pay and Educate included

Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

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.

| | |
|--|----------|
| <h3>Comprehensive Oncology Program</h3> <ul style="list-style-type: none"> • Care Management outreach • Case Management | Included |
| <h3>Healthy Pregnancies/Healthy Babies</h3> <ul style="list-style-type: none"> • Care Management outreach • Maternity Case Management • Neo-natal Case Management | |

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 percentile of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. 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.

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions

In Network: Coordinated by your physician

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

- 50% 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 - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing

In Network: Coordinated by your physician

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

- 50% 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 - 100

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.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.

3/1/2017

WA

Open Access Plus - Coinsurance - WA OAP - Coinsurance Plan - 5780714. Version# 8

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: macromastia or gynecomastia surgeries, other than surgery in connection with a mastectomy; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; cranosacral/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 dysfunction.
- 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. However, 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, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: 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; 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 (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 and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- 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

3/1/2017

WA

Open Access Plus - Coinsurance - WA OAP - Coinsurance Plan - 5780714. Version# 8

Exclusions

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.
- 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 unless determined by the utilization review Physician to be Medically Necessary.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- 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 that follows 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, 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 per-formed 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.
- Nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.

3/1/2017

WA

Open Access Plus - Coinsurance - WA OAP - Coinsurance Plan - 5780714. Version# 8

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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