

SUMMARY OF BENEFITS Cigna Health and Life Insurance Company



Knox County Government, 2012, Option 3

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-Existing Condition Limitation (PCL)	None	
Coinsurance	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<p>Maximum Reimbursable Charge • Determined based on the lesser of: • the health care professional’s normal charge for a similar service; or • a percentage 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 will not be 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. • Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.</p>	N/A	110%
<p>Calendar year deductible • One way cross accumulation: out-of-network deductible expenses go to in-network deductible expenses... • After each family member meets his or her individual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family deductible has been met, each individual’s claims will be paid by the plan, less any coinsurance amount.</p>	<p>Individual \$500 Family \$1,000</p>	<p>Individual \$1,500 Family \$3,000</p>
<p>Calendar year out-of-pocket maximum • One way cross accumulation: out-of-network out-of-pocket expenses go to in-network out-of-pocket expenses • Deductibles count towards your out-of-pocket maximum. • Mental health and substance abuse services count towards your out-of-pocket maximum. • After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual’s covered expenses.</p>	<p>Individual \$2,000 Family \$4,000</p>	<p>Individual \$6,000 Family \$12,000</p>



Benefits	In-network	Out-of-network
Physician Services		
Office visit	Primary care physician You pay \$30 per visit Specialist You pay \$40 per visit	You pay 50% Plan pays 50% After the deductible is met
Physician Services (hospital) <ul style="list-style-type: none"> In hospital visits and consultations Surgery 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Surgery (in a physician's office)	Primary care physician You pay \$30 per visit Specialist You pay \$40 per visit	You pay 50% Plan pays 50% After the deductible is met
Preventive Care <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman and adult preventive care Immunizations are covered at no charge Unlimited plan year maximum 	You pay 0% Plan pays 100% Plan deductible does not apply	Covered in-network only
Mammogram, PSA, Pap Smear & Colorectal Screenings <ul style="list-style-type: none"> This includes the reading and interpretation of these services This includes associated outpatient professional (radiology and/or pathology services) The associated exam will be covered at no charge 	You pay 0% Plan pays 100% Plan deductible does not apply	Covered in-network only
Inpatient Hospital Facility Services		
Semi-private room and board and other non-physician services <ul style="list-style-type: none"> In-patient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists, and anesthesiologists 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Multiple surgical reduction <ul style="list-style-type: none"> Multiple surgeries performed during one operating session result in payment reduction of 50% of the surgery of the lesser charge. The most expensive procedure is paid as any other surgery. 	Included	Included
Outpatient surgery (facility charge)	You pay a \$150 copay, then no charge	You pay 50% Plan pays 50% After the deductible is met
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists, and anesthesiologists; in-network lab/x-ray readings and interpretations are covered at 100% 	You pay 0% Plan pays 100% Plan deductible does not apply	You pay 50% Plan pays 50% After the deductible is met



Benefits	In-network	Out-of-network
Physical, occupational, cognitive, and speech therapy <ul style="list-style-type: none"> 60 days per calendar year for all therapies combined Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation, cardiac rehabilitation, chiropractic therapy and cognitive therapy 	Primary care physician You pay \$30 per visit Specialist You pay \$40 per visit	You pay 50% Plan pays 50% After the deductible is met
Lab and X-ray		
Lab and X-ray <ul style="list-style-type: none"> Physician's office Independent x-ray and/or lab facility Outpatient hospital facility Emergency room 	Office visit copayment; if none charged for, then no copayment You pay \$0 You pay \$0 You pay 20%; Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Advanced radiological imaging -MRI, MRA, CT, PET Scans <ul style="list-style-type: none"> Physician's office Inpatient hospital facility, outpatient hospital facility Emergency room or urgent care facility 	No copayment; no deductible \$125 per scan copay, then You pay 20% Plan pays 80% After the deductible is met \$0 copay; you pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Emergency an urgent care services		
Hospital emergency room <ul style="list-style-type: none"> Includes radiology, pathology, and physician charges Out-of-network charges are covered at the in-network rate 	\$150 facility copay, then You pay 20% Plan pays 80% After the deductible is met	Paid as in-network if a true emergency; otherwise, You pay 50% Plan pays 50% After the deductible is met
Ambulance Out-of-network services are covered at the in-network rate if it is a true emergency. If it is not a true emergency, the out-of-network rate is charged.	You pay 20% Plan pays 80% After the deductible is met	Paid as in-network if a true emergency; otherwise, You pay 50% Plan pays 50% After the deductible is met
Urgent care services Out-of-network services are covered at the in-network rate	You pay \$30 per visit	Paid as in-network if true urgent care; otherwise, You pay 50% Plan pays 50% After the deductible is met
Other healthcare facilities		
Skilled nursing facility, rehabilitation hospital and other facilities <ul style="list-style-type: none"> 100 days per calendar year 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Home health care <ul style="list-style-type: none"> 60 days per calendar year 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Hospice <ul style="list-style-type: none"> Inpatients services Outpatient services 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met



Benefits	In-network	Out-of-network
Other health care services		
Durable medical equipment	<p>You pay 20% Plan pays 80% After the deductible is met</p>	<p>You pay 50% Plan pays 50% After the deductible is met</p>
External prosthetic appliances (EPA)	<p>You pay 20% Plan pays 80% After the deductible is met</p>	<p>You pay 50% Plan pays 50% After the deductible is met</p>
TMJ, surgical and non-surgical <ul style="list-style-type: none"> • Physician's office • Inpatient • Outpatient 	<p>You pay \$30 or \$40 You pay 20%; Plan pays 80% After the deductible is met You pay \$150</p>	<p>You pay 50% Plan pays 50% After the deductible is met</p>
Dental care Dental care is limited to: <ul style="list-style-type: none"> • Treatment of an injury to a jaw or sound natural teeth due to an accident • Service for a covered dependent because of congenital disease or anomaly • Removal of impacted wisdom teeth when embedded in bone • Anesthesia expenses, hospital expenses and physician expenses associated with any hospital dental procedure performed on a child 8 years or younger or a mentally disabled adult, if the procedure itself is a covered expense 	<p>See place of service costs</p>	<p>You pay 50% Plan pays 50% After the deductible is met</p>
Bariatric surgery Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. All services are subject to Medical Necessity Approval) <ul style="list-style-type: none"> • Physician's Office • Inpatient Facility • Outpatient Surgical Facility • Physician's Services The following services are excluded: <ul style="list-style-type: none"> • Medical and surgical services to alter appearance or physical changes as a 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 	<p>See place of service costs</p>	<p>Covered in-network only</p>
Infertility services <ul style="list-style-type: none"> • 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. 	<p>See place of service costs</p>	<p>Covered in-network only</p>



Benefits	In-network	Out-of-network
Family planning <ul style="list-style-type: none"> Office Visits Inpatient hospital facility Outpatient facility Physician services Surgical services such as tubal ligation or vasectomy are covered (excluding reversals) Includes contraceptive devices 	See place of service costs	Covered in-network only
Maternity care <ul style="list-style-type: none"> Initial office visit to confirm pregnancy Global maternity fees (prenatal visits, postnatal visits, physician's delivery charges) Office visits not included in the global maternity fee Delivery - facility (inpatient hospital/birthing center charges) 	You pay \$30 or \$40 You pay 20%; Plan pays 80% After the deductible is met You pay \$30 or \$40 You pay 20%; Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Mental health and substance abuse services		
Inpatient services <ul style="list-style-type: none"> Unlimited days per calendar year 	You pay 20% Plan pays 80% After the deductible is met	You pay 50% Plan pays 50% After the deductible is met
Outpatient services <ul style="list-style-type: none"> Unlimited visits per calendar year Office visit Out-patient facility 	You pay \$30 or \$40 You pay \$150	You pay 50% Plan pays 50% After the deductible is met
Prescription drugs		
CIGNA Step Therapy <ul style="list-style-type: none"> Applies to prescriptions for high blood pressure, stomach acid, and high cholesterol 	Generic or preferred brand drug must be used before using the non-preferred brand	Covered in-network only
CIGNA Pharmacy three-tier plan <ul style="list-style-type: none"> Retail calendar year plan deductible: Home delivery plan deductible: 	Individual \$100 Family \$200 Retail (30 day supply) You pay after plan deductible: Generic: \$4 Preferred Brand: \$40 Non-preferred brand: \$60 None Home Delivery (90 day supply) You pay: Generic: \$8 Preferred Brand: \$80 Non-preferred brand: \$120	Covered in-network only

Benefits	In-network	Out-of-network
Preventive Maintenance Medications <ul style="list-style-type: none"> No deductible applies 	<p>Retail (30 day supply) You pay: Generic: \$0 Preferred Brand:\$40 Non-preferred brand:\$60</p> <p>Home Delivery (90 day supply) Generic: \$0 Preferred Brand: \$80 Non-preferred brand: \$120</p>	Covered in-network only
Prescription Smoking Cessation Medications <ul style="list-style-type: none"> No deductible applies 	<p>Retail (30 day supply) You pay: \$0</p> <p>Home Delivery (90 day supply) \$0</p>	Covered in-network only
Vision Care <ul style="list-style-type: none"> Eye exam every 12 months No hardware included 	You pay \$10	Not covered

Definitions

Deductible – The amount you need to pay before your plan starts paying benefits. **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. **Out-of-pocket** – The amount you need to pay each year before your plan starts paying benefits (may or may not include your deductible). **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.

Exclusions

What’s Not Covered (not all-inclusive): Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren’t limited to): • Services provided through government programs • Services that aren’t medically necessary • Experimental, investigational or unproven services • Services for an injury or illness that occurs while working for pay or profit including services covered by worker’s compensation benefits • Cosmetic services • Dental care, unless due to accidental injury to sound natural teeth • Infertility Services • Reversal of sterilization procedures • Genetic screenings • Obesity services • Non-prescription and anti-obesity drugs • Custodial and other non-skilled services • Weight loss programs • Hearing aids • Acupuncture • Treatment of sexual dysfunction • Travel immunizations • Telephone, email and internet consultations in the absence of a specific benefit • Eyeglass lenses and frames, contact lenses and surgical vision correction

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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