# BENEFIT SUMMARY

**Cigna HealthCare of California, Inc. and Connecticut General Life Insurance Co.**
**For - City of Santee**
**HMO POS**
**HMO POS**
**Effective - 01/01/2025**

**Selection of a Primary Care Provider** - This Plan requires 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. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of 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.

**Referrals are required for a specialist visit** - Your PCP must submit a referral for you to see a specialist, with only some exceptions. Exceptions include OB/GYN, Behavioral Providers and State Required Direct Access Providers.

**Direct Access to Obstetricians and Gynecologists** - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Plan Year Accumulation** | Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a contract year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. | |
| **Plan Coinsurance** | Plan pays 100% | Plan pays 70% |
| **Maximum Reimbursable Charge** | Not Applicable | 110% |
| **Plan Deductible** | Individual: None<br>Family: None | Individual: $300<br>Family: $600 |

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Out-of-Pocket Maximum** | Individual: $1,500<br>Family: $3,000 | Individual: $3,000<br>Family: $6,000 |

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the 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.

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $20 copay, and plan pays 100% | Plan pays 70% ^ |
| **Specialty Care Physician Services/Office Visit**<br>• Referrals from your PCP are required. | $20 copay, and plan pays 100% | Plan pays 70% ^ |
| **Surgery Performed in Physician's Office** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Allergy Treatment/Injections and Allergy Serum**<br>Allergy serum dispensed by the physician in the office<br><br>**Note:** Office copay does not apply if only the allergy serum is provided. | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | $20 copay, and plan pays 100% | Not Covered |

- Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

| | | |
|---|---|---|
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $20 copay, and plan pays 100% | Plan pays 70% ^ |
| **Specialty Care Physician Services/Office Visit** | $20 copay, and plan pays 100% | Plan pays 70% ^ |

- Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).
- Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Preventive Care** | | |
| **Preventive Care**<br>Birth through age 16<br><br>Ages 17 and older | Plan pays 100%<br><br>Plan pays 100% | PCP: Plan pays 70% ^<br>Specialist: Plan pays 70% ^<br><br>Not Covered |
| • Includes Well-Baby, Well-Child, Well-Woman and Adult Preventive Care<br>• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. | | |
| **Immunizations**<br>Birth through age 16<br><br>Ages 17 and older | Plan pays 100%<br><br>Plan pays 100% | PCP: Plan pays 70% ^<br>Specialist: Plan pays 70% ^<br><br>Not Covered |
| **Mammogram, PAP, and PSA Tests** | Plan pays 100% | Covered same as other x-ray and lab services, based on Place of Service |
| • Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.<br>• Associated wellness exam is covered in-network only. | | |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | $150 per admission copay, and plan pays 100% | $300 per admission deductible, and plan pays 70% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 100% | Plan pays 70% ^ |
| **Inpatient Professional Services** | Plan pays 100% | Plan pays 70% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Outpatient** | | |
| **Outpatient Facility Services**<br>Non-surgical treatment procedures are not subject to the facility per visit copay. | $75 per facility visit copay, and plan pays 100% | $150 per facility visit deductible, and plan pays 70% ^ |
| **Outpatient Professional Services** | Plan pays 100% | Plan pays 70% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Emergency Services** | | |
| **Emergency Room**<br>• Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.<br>• Per visit copay is waived if admitted. | $50 copay, and plan pays 100% | $50 copay, and plan pays 100% |
| **Urgent Care Facility**<br>• Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit. | $25 copay, and plan pays 100% | $25 copay, and plan pays 100% |
| **Ambulance** | Plan pays 100% | Plan pays 100% |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Inpatient Services at Other Health Care Facilities** | | |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities**<br>• Annual Limit: 100 days per contract year in-network<br>• Annual Limit: 60 days per contract year out-of-network | Plan pays 100% | Plan pays 70% ^ |
| **Laboratory Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Independent Lab** | Plan pays 100% | Plan pays 70% ^ |
| **Outpatient Facility** | Plan pays 100% | Plan pays 70% ^ |
| **Radiology Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Facility** | Plan pays 100% | Plan pays 70% ^ |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | Plan pays 100% | Plan pays 70% ^ |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Therapy Services** | | |
| **Outpatient Therapy Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limits:<br>• All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days<br><br>**Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum. | | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Chiropractic Services**<br>Annual Limit:<br>• Chiropractic Care - 20 days | $20 PCP or $20 Specialist copay | Not Covered |
| **Cardiac Rehabilitation Services**<br>Annual Limit:<br>• Cardiac Rehabilitation - Unlimited days | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 100% | Plan pays 70% ^ |
| **Outpatient Services** | Plan pays 100% | Not Covered |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Bereavement Counseling (for services not provided as part of a hospice program)** | | |
| Services Provided by a Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Maternity** | | |
| **Initial Visit to Confirm Pregnancy** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges** (Global Maternity Fee) | Plan pays 100% | Plan pays 70% ^ |
| **Office Visits in Addition to Global Maternity Fee** (Performed by OB/GYN or Specialist) | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Delivery - Facility**<br>(Inpatient Hospital, Birthing Center) | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |
| **Abortion** | | |
| **Abortion Services**<br>**Note:** Elective and non-elective procedures | Plan pays 100% | Plan pays 100% |
| **Family Planning** | | |
| **Women's Services**<br>Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals) | Plan pays 100% | Coverage varies based on Place of Service |
| **Men's Services**<br>Includes surgical sterilization services, such as vasectomy (excludes reversals) | Plan pays 100% | Coverage varies based on Place of Service |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Infertility** | | |
| **Infertility Treatment**<br>**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. | | |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care** | Plan pays 100% | Plan pays 70% ^ |
| • Annual Limit: 100 days In-Network. 40 days Out-of-Network. (The limit is not applicable to mental health and substance use disorder conditions.)<br>• 16 hour maximum per day<br>**Note:** Includes outpatient private duty nursing when approved as medically necessary | | |
| **Organ Transplants** | Coverage varies based on Place of Service at In-Network cost share | Not Covered |
| • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.<br>• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime | | |
| **Durable Medical Equipment**<br>• Annual Limit: Unlimited | Plan pays 100% | Not Covered |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician<br>• Includes related supplies | Plan pays 100% | Not Covered |
| **External Prosthetic Appliances (EPA)** | Plan pays 100% | Not Covered |
| • Annual Limit: Unlimited | | |
| **Temporomandibular Joint Disorder (TMJ)** | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment. | | |
| **Routine Foot Care** | Not Covered | Not Covered |
| **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary. | | |
| **Acupuncture**<br>• Annual Limit: 20 days | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | $150 per admission copay, and plan pays 100% | $300 per admission deductible, and plan pays 70% ^ |
| **Outpatient Mental Health – Physician's Office** | $20 copay, and plan pays 100% | Plan pays 70% ^ |
| **Outpatient Mental Health – All Other Services** | Plan pays 100% | Plan pays 70% ^ |
| **Inpatient Substance Use Disorder** | $150 per admission copay, and plan pays 100% | $300 per admission deductible, and plan pays 70% ^ |
| **Outpatient Substance Use Disorder – Physician's Office** | $20 copay, and plan pays 100% | Plan pays 70% ^ |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Outpatient Substance Use Disorder – All Other Services** | Plan pays 100% | Plan pays 70% ^ |
| Annual Limits:<br>• Unlimited maximum<br><br>Notes:<br>• Inpatient includes Acute Inpatient and Residential Treatment.<br>• Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.<br>• Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.<br>• Services are paid at 100% after you reach your out-of-pocket maximum.<br><br>**Important Note on Mental Health and Substance Use Disorder Coverage:** Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled “Mental Health and Substance Use Disorder.” | | |
| **Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs**<br><br>**Inpatient and Outpatient Management**<br>• Inpatient utilization review and case management<br>• Outpatient utilization review and case management<br>• Partial Hospitalization<br>• Intensive outpatient programs<br>• Changing Lives by Integrating Mind and Body Program<br>• Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.<br>• Narcotic Therapy Management<br>• inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions. | | |

| Pharmacy | In-Network |
|---|---|
| **Cost Share and Supply** | |
| **Cigna Pharmacy Plus Cost Share**<br>• Retail – up to 90-day supply<br>• Home Delivery – up to 90-day supply | **Retail (per 30-day supply):**<br>Generic: You pay $15<br>Preferred Brand: You pay $30<br>Non-Preferred Brand: You pay $45<br><br>**Retail (per 90-day supply):**<br>Generic: You pay $45<br>Preferred Brand: You pay $90<br>Non-Preferred Brand: You pay $135<br><br>**Home Delivery (per 90-day supply):**<br>Generic: You pay $40 |

| Pharmacy | In-Network |
|---|---|
| | Preferred Brand: You pay $85<br>Non-Preferred Brand: You pay $130 |
| • **Cigna 90 Now CVS:** 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. Walgreens will be considered Out-of-Network for a 90 day supply.<br>• 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 network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.<br>• Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.<br>• When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW). | |
| **Pharmacy Out-of-Pocket Maximum**<br>• Retail and Home Delivery cost share applies to the Pharmacy Out-of-Pocket. | Individual: $1,500<br>Family: $3,000 |

## Drugs Covered

**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.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

## Pharmacy Program Information

**Pharmacy Clinical Management: Essential**

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

## 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.

**Cigna Diabetes Prevention Program in collaboration with Omada**

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

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| **Comprehensive Oncology Program**<br>• Care Management outreach<br>• Case Management | Included |
| **Healthy Pregnancies/Healthy Babies**<br>• Care Management outreach<br>• Maternity Case Management<br>• Neo-natal Case Management | $150 (1st trimester) / $75 (2nd trimester) - Option 3 |

## Additional Information

**Maximum Reimbursable Charge**
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) 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 based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations.

**Out-of-Network Emergency Services Charges**
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

**Medicare Coordination**
In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

**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.

**One Guide**
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

## Additional Information

**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.

- 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 - 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.

- 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.

**Well-Being Solution: Core Plus**

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges

**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 out-of-network deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
**Place of service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.
**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
**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; provided, however, that this exclusion shall not operate to exclude coverage for services provided to a Member confined in a city or county jail or in a juvenile facility, solely because of such confinement, or for services provided to a Member while confined in a state hospital, solely because the services were provided in a state hospital.
- Services required by state or federal law to be supplied by a public school system or school district that are directed by or coordinated through the public school system or the school district rather than through a Participating Provider other than those services described under Section IV. Covered Services and Supplies, Autistic Disorders.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- 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.
- Any services and supplies for or in connection with experimental, investigational and unproven services as defined in "Section I. Definitions of Terms Used in this Group Service Agreement."
- Cosmetic surgery or therapy except as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies."
- The following services are excluded unless Medically Necessary:
    - Macromastia or Gynecomastia Surgeries - Macromastia surgery is the surgical excision of enlarged female breast tissue, skin and fat in order to decrease the size of the breast. Gynecomastia surgery is a procedure to treat benign enlargement of the male breast;
    - Surgical treatment of varicose veins;
    - Abdominoplasty - Abdominoplasty, also referred to as a "tummy tuck" is a surgical procedure that tightens a lax anterior abdominal wall and removes excess abdominal skin (panniculectomy component). It is generally to improve appearance by recontouring the abdominal wall area;
    - Panniculectomy - Panniculectomy is the surgical excision of redundant panniculus adiposus (the superficial fascia which contains an abundance of fat tissue);
    - Rhinoplasty;
    - Blepharoplasty - Blepharoplasty refers to the surgical excision of redundant tissues (muscle, fat, skin) of the eyelids;
    - Redundant skin surgery;

## Exclusions

- Removal of skin tags.

- The following services are excluded from coverage regardless of clinical indications:
  - Acupressure;
  - Craniosacral/cranial therapy - Craniosacral therapy (CST), also called cranial therapy, is an unproven non-invasive treatment that utilizes diagnostic touching to detect reported pulsations and rhythms of the flow of cerebrospinal fluid to effect a release of possible restrictions without the use of forceful manipulation. CST has been utilized for a variety of both musculoskeletal and general medical conditions. Some reported clinical applications of CST include acute systemic infections, chronic pain conditions, localized infection, dysfunctions of the viscera (e.g., ulcerative bowel conditions, asthma), depression, strabismus, auditory problems, developmental delay, and autism. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
  - Dance therapy;
  - Applied kinesiology - Applied kinesiology is a system using muscle testing as a functional neurological evaluation. The methodology is concerned primarily with neuromuscular function as it relates to the structural, chemical and mental physiologic regulatory mechanisms. A.K., which originated within the chiropractic profession, is an approach to clinical practice, with multidisciplinary applications. The safety and efficacy of this technique has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions";
  - Rolfing;
  - Prolotherapy - Prolotherapy is the injection of a solution for the purpose of tightening and strengthening loose or weak tendons, ligaments or joint capsules through the multiplication and activation of fibroblasts. The safety and efficacy of this treatment has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"; and
  - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions - Extracorporeal shock wave therapy (ESWL) is a noninvasive treatment that involves delivery of 1000 to 3000 shock waves to the painful musculoskeletal region, and has been proposed as an alternative to surgery. The mechanism by which ESWL might work to relieve pain associated is unknown and the efficacy has not been proven. If you feel that any of these services have been denied on the basis of being experimental, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".
- 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 (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least fifty (50%) percent bony support and are functional in the arch.
- 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 (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based scientific literature and scientifically-based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity, unless Medically Necessary or as specified in the "Reconstructive Surgery" section of "Section IV. Covered Services and Supplies"; and
  - Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.

## Exclusions

- Unless otherwise covered as a basic benefit, 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 being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
- Infertility services, infertility drugs, surgical or medical treatment programs for infertility.
- Reversal of male and female voluntary sterilization procedures.
- Treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation. However, Medically Necessary treatment and penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services including but not limited to, Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs and driving safety. Behavioral training and services, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation are also excluded except as specified in the "Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child" section of "Section IV. Covered Services and Supplies."
- Consumable medical supplies other than ostomy supplies, urinary catheters and diabetic supplies. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies including skin preparations, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Diabetic Services", "Diabetic Supply Coverage", "Durable Medical Equipment" and "Home Health Care Services", sections of "Section IV. Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the "Home Health Care Services" section of "Section IV. Covered Services and Supplies." or unless determined to be Medically Necessary by the Healthplan Medical Director in consultation with the Member's treating Physician.
- 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 illness or injury.
- Artificial aids including, but not limited to, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Corrective orthopedic shoes, unless medically necessary or as specified in the "Orthoses and Orthotic Devices" section of "Section IV. Covered Services and Supplies".
- 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 non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Routine refraction.
- Corrective eyeglass lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following cataract surgery.
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All prescription drugs, non-prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, and investigational and experimental drugs (except as specified in "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions"), and "Section IV. Covered Services and Supplies."
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies, and peripheral vascular disease are covered.

## Exclusions

- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Dental implants for any condition.
- Genetic screening or pre-implantation 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, except as provided in the "Genetic Testing" section of "Section IV. Covered Services and Supplies."
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director'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.
- Enteral feedings, supplies and specialty formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- Massage therapy.

**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, service agreement 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.

*Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of California, Inc.*

EHB State: CA

# Discrimination is against the law.

## Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Cigna Healthcare:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - Information written in other languages

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**Cigna Healthcare**
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services** 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**



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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).

**Cigna Healthcare Financial Exhibit for:**

# City of Santee

## DPPO

**Effective Date: January 01, 2025**

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.
Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

| Plan Design | Total Cigna DPPO | Out-of-Network |
|---|---|---|
| **Calendar Year Maximum** | | |
| (Class I, II, III, IX Expenses) | $2500, Class I Applies | $2500, Class I Applies |
| **Calendar Year Deductible** | | |
| Per Individual | $50 | $50 |
| Per Family | $150 | $150 |
| **Class I Expenses - Preventive & Diagnostic Care** | | |
| Oral Exams<br>Cleanings<br>Routine X-rays<br>Fluoride Application<br>Sealants<br>Space Maintainers (limited to non-orthodontic treatment)<br>Non-Routine X-rays<br>Emergency care to relieve pain (administrated at In Network coinsurance) | 100%, No Deductible | 100%, No Deductible |
| **Class II Expenses - Basic Restorative Care** | | |
| Fillings (Amalgam and composite on all teeth)<br>Oral Surgery - Simple Extractions<br>Oral Surgery - All Except Simple Extraction<br>Surgical Extraction of Impacted Teeth<br>Anesthetics<br>Minor Periodontics<br>Major Periodontics<br>Root Canal Therapy / Endodontics<br>Relines, Rebases, and Adjustments<br>Brush Biopsy | 90%, After Deductible | 80%, After Deductible |
| **Class III Expenses - Major Restorative Care** | | |
| Repairs - Bridges, Crowns, and Inlays<br>Repairs - Dentures<br>Crowns/Inlays/Onlays<br>Stainless Steel/Resin Crowns<br>Dentures<br>Bridges | 60%, After Deductible | 50%, After Deductible |
| **Class IV Expenses - Orthodontia** | | |
| Coverage for Eligible Children Only | 50%, No Ortho Deductible | 50%, No Ortho Deductible |
| Lifetime Maximum | $2000 | $2000 |
| **Class V Expenses - TMJ** | | |
| Lifetime Maximum | 50%, After Deductible<br>$1000 | 50%, After Deductible<br>$1000 |
| **Class IX Expenses - Implants** | | |
| Plan Calendar Year Max | 60%, After Deductible<br>$2500 | 50%, After Deductible<br>$2500 |
| **Dental Plan Reimbursement Levels** | Based on Contracted Fees | 90th Percentile of Submitted Charges*** |
| **Additional Member Responsibility in excess of Coinsurance** | None | Yes, the difference between the member's dentist's billed charges and the dental plan reimbursement level*** |
| **Student/Dependent Age** | 26/26 | |

**Cigna Healthcare Financial Exhibit for:**

# City of Santee

# DPPO

**Effective Date: January 01, 2025**

## *Cigna Dental PPO / Indemnity Exclusions and Limitations:*

| Procedure | Exclusions & Limitations |
|---|---|
| Exams | Two per calendar year |
| Prophylaxis (cleanings) | Four per calendar year |
| Fluoride | 1 per calendar year for people under 19 |
| X-Rays (routine) | Bitewings: 2 per calendar year |
| X-Rays (non-routine) | Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years |
| Cone Beams | Not covered |
| Model | Payable only when in conjunction with Ortho workup |
| Minor Perio (non-surgical) | Various limitations depending on the service |
| Perio Surgery | Various limitations depending on the service |
| Crowns and Inlays | Replacement every 5 years |
| Prosthesis over Implants | 1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges. |
| Bridges | Replacement every 5 years |
| Dentures and Partials | Replacement every 5 years |
| Relines, Rebases | Covered if more than 6 months after installation |
| Adjustments | Covered if more than 6 months after installation |
| Repairs - Bridges | Reviewed if more than once |
| Repairs - Dentures | Reviewed if more than once |
| Sealants | Limited to posterior tooth. One treatment per tooth every three years up to age 14 |
| Space Maintainers | Limited to non-Orthodontic treatment. No frequency limit for participants under age 19. |
| Alternate Benefit | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. |
| Orthodontia | For dependent children, up to age 19 |
| Missing Tooth Provision | No Limitation (teeth missing prior to the effective date of coverage are covered) |
| Late Entrant Limit**** | 50% coverage on Class III, IV (if applicable), V, and IX for 12 months |
| Pre-Treatment Review | Available on a voluntary basis when extensive work in excess of $200 is proposed |

## *Benefit Exclusions:*

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

*** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.*

****Charges are based upon an independent third party organization that is the industry standard. Percentile data is based upon the third party organization's aggregated industry-wide claims data*

*****Late Entrant coverage limitation does not apply to New Mexico Residents for Insured Dental Products.*

*This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.*

*Benefits are insured and/or administered by Cigna HealthCare.*

Did you know that most of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can access articles on behavioral conditions that impact oral health.



*Prepared by Underwriting.*

# DISCRIMINATION IS AGAINST THE LAW.

## Dental coverage

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Nondiscrimination Complaint Coordinator
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Chattanooga, TN 37422

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**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
**1.800.368.1019, 800.537.7697 (TDD)**

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**http://www.hhs.gov/ocr/office/file/index.html**



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## Proficiency of Language Assistance Services

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**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).