

## SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.**  
**For - BorgWarner Inc.**  
**Indemnity Plan: 2019 Sterling Hgts Pre Medicare Retirees After 3/90 (Medicare Rx)**  
**Benefit Option: IND7**

**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 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 health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	Benefit Amount
<b>Lifetime Maximum</b>	Unlimited
<b>Coinsurance</b>	Your plan pays 80%
<b>Maximum Reimbursable Charge</b>	90th Percentile
<b>Calendar Year Deductible</b>	Individual: \$350 Family: \$700
<ul style="list-style-type: none"> <li>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.</li> </ul>	
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).	
<b>Calendar Year Out-of-Pocket Maximum</b>	Individual: \$1,370 Family: \$2,740
<ul style="list-style-type: none"> <li>Plan deductible does not contribute towards your out-of-pocket maximum.</li> <li>Benefit deductibles contribute towards the out-of-pocket maximum.</li> <li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li> <li>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.</li> </ul>	

Benefit	Benefit Amount
<b>Physician Services</b>	
<b>Physician Office Visit – Primary Care Physician (PCP)/Specialist</b>	After the plan deductible is met, your plan pays 80%
<ul style="list-style-type: none"> <li>All services including Lab &amp; X-ray</li> </ul>	
<b>Surgery Performed in Physician's Office</b>	Plan pays 100%
<b>Second Surgical Opinion</b>	After the plan deductible is met, your plan pays 80%
<b>Allergy Treatment/Injections Performed in Physician's Office</b>	After the plan deductible is met, your plan pays 80%

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Benefit	Benefit Amount
<b>Allergy Serum</b> <ul style="list-style-type: none"> <li>Dispensed by the physician in the office</li> </ul>	After the plan deductible is met, your plan pays 80%
<b>Cigna Telehealth Connection Services</b> <ul style="list-style-type: none"> <li>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)</li> </ul>	After the plan deductible is met, your plan pays 80%
<b>Preventive Care</b>	
<b>Preventive Care - All Ages</b> <ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit</li> <li>Includes one routine exam and routine lab and x-ray</li> <li>Excludes routine colonoscopy, sigmoidoscopy, etc.</li> </ul>	After the plan deductible is met, your plan pays 80%
<b>Immunizations</b>	Not Covered
<b>Mammogram</b> (routine and diagnostic) <ul style="list-style-type: none"> <li>Coverage includes the associated Outpatient Professional Services.</li> </ul>	Plan pays 100%
<b>PAP and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	After the plan deductible is met, your plan pays 80%
<b>Inpatient</b>	
<b>Inpatient Hospital Facility</b>	Plan pays 80%
<b>Semi-Private Room:</b> Limited to semi-private rate	
<b>Private Room:</b> Limited to semi-private rate	
<b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> Limited to ICU/CCU daily room rate	
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 80%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 80%
<b>Outpatient</b>	
<b>Outpatient Facility Services</b>	Surgical: Plan pays 100% Non-surgical: Plan pays 80%
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 80%

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Benefit	Benefit Amount
<p><b>Short-Term Rehabilitation</b></p> <p>Calendar Year Maximums:</p> <ul style="list-style-type: none"> <li>Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days</li> </ul> <p><b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</p>	<p>After the plan deductible is met, your plan pays 80%</p>
<p><b>Chiropractic Care</b></p> <p>Calendar Year Maximum:</p> <ul style="list-style-type: none"> <li>Chiropractic Care – \$500 maximum per calendar year</li> </ul> <p><b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.</p>	<p>After the plan deductible is met, your plan pays 80%</p>
<p><b>Other Health Care Facilities/Services</b></p>	
<p><b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity)</p> <ul style="list-style-type: none"> <li>Unlimited days maximum per Calendar Year</li> <li>16 hour maximum per day</li> <li>\$5,000 maximum per Calendar Year for outpatient Private Duty Nursing</li> </ul>	<p>Plan pays 80%</p>
<p><b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b></p> <ul style="list-style-type: none"> <li>Unlimited days maximum per Calendar Year</li> </ul>	<p>Plan pays 80%</p>
<p><b>Durable Medical Equipment</b></p> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	<p>After the plan deductible is met, your plan pays 80%</p>
<p><b>External Prosthetic Appliances (EPA)</b></p> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	<p>After the plan deductible is met, your plan pays 80%</p>
<p><b>Routine Foot Disorders</b></p> <p>Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.</p>	<p>Not Covered</p>
<p><b>Hearing Services</b></p> <ul style="list-style-type: none"> <li>Includes audiometric exam, hearing evaluation &amp; testing and audiology services</li> <li>Limited to 1 exam every 36 months</li> <li>Limited to 1 hearing aid/ear every 36 months</li> <li>Includes testing and fitting of hearing aid devices</li> </ul>	<p>Plan pays 100%</p>
<p><b>Chemotherapy and Radiation Therapy</b></p>	<p>Plan pays 80%</p>

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

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

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
<b>Pre-Admission Testing</b>	Plan pays 80%	Plan pays 80%	Not Applicable	Plan pays 80%
<b>Laboratory</b>	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
<b>Radiology</b>	Plan pays 80%	Not Applicable	Plan pays 80%	Plan pays 80%
<b>Advanced Radiology Imaging</b>	Plan pays 80%	Not Applicable	Plan pays 80%	Plan pays 80%

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
	Benefit Amount	Benefit Amount	Benefit Amount
<b>Emergency Care</b>	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^
<b>Urgent Care</b>	Plan pays 80% ^	Plan pays 80% ^	Not Applicable*

\*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	Benefit Amount	Benefit Amount
<b>Hospice</b>	Plan pays 100%	Plan pays 100%
<b>Bereavement Counseling</b>	Plan pays 100%, up to \$25 per visit	Plan pays 100%, up to \$25 per visit

- Lifetime Maximum: Up to \$7,000 for Inpatient services
- Bereavement counseling limited to 12 visits per occurrence

Note: Services provided as part of Hospice Care Program

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

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)
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
<b>Maternity</b>	Plan pays 80% ^	Plan pays 80%	Plan pays 80%	Covered same as plan's Inpatient Hospital benefit

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

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount	Benefit Amount
<b>Abortion</b> (Non-elective procedures)	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Plan pays 80%	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Plan pays 80%	Plan pays 80%
<b>Family Planning - Men's Services</b>	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Plan pays 80%	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Plan pays 80%	Plan pays 80%
<ul style="list-style-type: none"> <li>Includes surgical services, such as vasectomy (excludes reversals)</li> </ul>					
<b>Family Planning - Women's Services</b>	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Surgical: Plan pays 100% Non-surgical: Plan pays 80%	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Plan pays 80%	Plan pays 80%
<ul style="list-style-type: none"> <li>Includes surgical services, such as tubal ligation (excludes reversals)</li> <li>Excludes coverage for contraceptive services</li> </ul>					
<b>Infertility</b>	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment; excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.					
<b>TMJ, Surgical</b>	Surgical: Plan pays 100% Non-surgical: Plan pays 80% ^	Surgical: Plan pays 80% Non-surgical: Plan pays 80% ^	Surgical: Plan pays 100% Non-surgical: Plan pays 80%	Plan pays 80%	Plan pays 80%
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime <ul style="list-style-type: none"> <li>Includes injections made directly into the Temporomandibular Joint</li> <li>Non-Surgical TMJ: Not Covered under Medical plan</li> </ul>					
Note: Services where plan deductible applies are noted with a caret (^).					
Benefit	Inpatient Hospital Facility		Inpatient Professional Services		
	Benefit Amount		Benefit Amount		
<b>Organ Transplants</b>	Plan pays 100% ^		Plan pays 100% ^		
<ul style="list-style-type: none"> <li>Organ Transplant Lifetime Maximum - \$1,000,000</li> </ul>					
Note: Services where plan deductible applies are noted with a caret (^).					
Benefit	Inpatient	Outpatient - Physician's Office		Outpatient - All Other Services	
	Benefit Amount	Benefit Amount		Benefit Amount	
<b>Mental Health</b>	Plan pays 80%	Plan pays 80% ^		Plan pays 80% ^	
<b>Substance Use Disorder</b>	Plan pays 80%	Plan pays 80% ^		Plan pays 80% ^	
Note: Services where plan deductible applies are noted with a caret (^).					

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Benefit	Inpatient	Outpatient - Physician's Office	Outpatient – All Other Services
	Benefit Amount	Benefit Amount	Benefit Amount

**Notes:**

- Maximums per Calendar Year
  - o Inpatient Mental Health and Substance Use Disorder: Unlimited days
  - o Outpatient Mental Health and Substance Use Disorder (office/facility): Unlimited visits
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization.

**Mental Health and Substance Use Disorder Services**

**Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs**

Inpatient Management Only

- Inpatient utilization review and case management

**Pharmacy**

Pharmacy benefits provided by Cigna/HealthSpring Medicare Rx Plan

**Plan Code:** EGWPG

**Plan Name:** StHgts EGWP - Plan #3 (RXPDH)

**Additional Information**

**Maximum Reimbursable Charge**

Payments made to health care professionals are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (90th) 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 state, regional or national charge data may be used. 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. 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. Services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

**Medicare Coordination**

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan 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, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, 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.

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

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## 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.

**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.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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. For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies,

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## Exclusions

supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
  - Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
  - The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
  - Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
  - 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 appearance 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.
  - Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), 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.
  - Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
  - 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 except as provided under the Home Health Services provision.
  - Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary

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## Exclusions

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.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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 performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All 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 non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

### 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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# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

- 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file

a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO 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](mailto: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  
<http://www.hhs.gov/ocr/office/file/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 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, 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 연락해주시고, 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**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 deyè 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せん。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).