

# SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.



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## Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html).

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

General Services	In-Network	Out-of-Network
<b>Physician office visit</b>	Primary care physician You pay \$20 copay per visit Specialist You pay \$30 copay per visit	You pay 50% Plan pays 50% after the deductible is met
<b>Urgent care visit</b> • All services including Lab & X-ray	Urgent care copay You pay \$30	You pay 50% Plan pays 50% after the deductible is met
<b>Preventive Care</b>	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
<b>Preventive Services</b>	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
<b>Immunizations</b>	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met

General Services	In-Network	Out-of-Network
<b>Performance pharmacy plan</b> <ul style="list-style-type: none"> <li>Includes contraceptives - with specific products covered at 100%</li> <li>If a Brand name drug is requested when there is a Generic equivalent, member must purchase the Generic drug, or pay 100% of the difference between the Brand name price and the Generic price, plus the appropriate brand-name copay (unless the physician indicates "Dispense As Written" DAW)</li> <li>Cigna National Pharmacy Network</li> <li>Specialty medications are limited to a 90-day supply</li> </ul>	<b>Retail</b> - (per 30 day supply) Tier 1: \$10 Tier 2: \$20 Tier 3: \$40 <b>Home Delivery</b> - (per 90 day supply) 2x 90-Day Retail supply at 3x retail copay	Member pays 100% at the time of purchase then reimbursed 50% after the applicable copay
<b>Coinsurance</b>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Calendar year deductible</b> <ul style="list-style-type: none"> <li>Carryover Deductible provision included but does not credit the out-of-pocket amount</li> <li>Deductible waived for in-network and out-of-network Lab &amp; X-ray in office or outpatient facility and for office surgery when performed in-network</li> <li>In-network and out-of-network expenses do not cross accumulate</li> </ul>	Individual \$500 Family \$1,500	Individual \$2,000 Family \$6,000
<b>Out-of-pocket annual maximum</b> <ul style="list-style-type: none"> <li>Medical copays do not apply towards the out-of-pocket maximum</li> <li>Medical deductibles do not apply towards out-of-pocket maximums</li> <li>Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums</li> </ul>	Individual \$2,500 Family \$7,500	Individual \$10,000 Family \$30,000
<b>Lifetime maximum</b>	Unlimited Per individual	
<b>Emergency room care</b> <ul style="list-style-type: none"> <li>All services rendered apply to ER benefit including Lab &amp; X-ray</li> </ul>	Emergency room copay You pay \$200	
<b>Ambulance</b> <ul style="list-style-type: none"> <li>Unlimited per day maximum</li> </ul>	You pay 10% Plan pays 90% after the in-network deductible is met	
<b>Office surgery</b>	You pay 10% Plan pays 90% no deductible	You pay 50% Plan pays 50% after the deductible is met
<b>Other office services</b> <ul style="list-style-type: none"> <li>100% after office visit copay</li> <li>Independent lab paid based on status of the facility</li> </ul>	Plan pays 100% after office visit copay	You pay 50% Plan pays 50% no deductible
<b>Outpatient lab and x-ray</b> <ul style="list-style-type: none"> <li>Independent Lab and X-ray paid based on status of the facility</li> </ul>	You pay 10% Plan pays 90% no deductible	You pay 50% Plan pays 50% no deductible

General Services	In-Network	Out-of-Network
<b>Office advanced radiology imaging services</b> <ul style="list-style-type: none"> <li>Includes MRI, MRA, PET, CT-Scan and Nuclear medicine</li> </ul>	Plan pays 100% after office visit copay	You pay 50% Plan pays 50% no deductible
<b>Outpatient advanced radiology imaging services</b> <ul style="list-style-type: none"> <li>Includes MRI, MRA, PET, CT-Scan and Nuclear medicine</li> </ul>	You pay 10% Plan pays 90% no deductible	You pay 50% Plan pays 50% no deductible
<b>Durable medical equipment</b> <ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> <li>Unlimited annual maximum</li> <li>Includes external prosthetic appliances</li> <li>Does accumulate towards the out-of-pocket maximum</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Breast-feeding equipment and supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies</li> </ul>	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met

Benefits	In-Network	Out-of-Network
<b>Hospital Services</b>		
<b>Inpatient hospital services</b> <ul style="list-style-type: none"> <li>Including anesthesia</li> <li>\$500 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.</li> <li>Inpatient Lab &amp; X-ray services are subject to the professional service reimbursement</li> </ul>	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay \$500 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
<b>Outpatient hospital services</b> <ul style="list-style-type: none"> <li>\$500 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.</li> <li>Outpatient surgery</li> <li>Including anesthesia</li> <li>Ambulatory Surgery</li> <li>Lab &amp; X-Ray paid based on facility network status</li> </ul>	Outpatient facility You pay 10% Plan pays 90% after the deductible is met	Outpatient facility You pay \$500 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
<b>Skilled nursing facility care</b> <ul style="list-style-type: none"> <li>100 days per calendar year maximum</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Hospice care</b>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Home health care</b> <ul style="list-style-type: none"> <li>100 visits per calendar year maximum</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Mental Health and Substance Use Disorder</b>		

Benefits	In-Network	Out-of-Network
<b>Inpatient mental health</b> <ul style="list-style-type: none"> <li>\$500 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.</li> </ul>	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay \$500 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
<b>Inpatient substance use disorder</b> <ul style="list-style-type: none"> <li>\$500 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.</li> </ul>	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay \$500 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
<b>Outpatient mental health – all other services</b>	You pay 10% Plan pays 90%	You pay 50% Plan pays 50%
<b>Outpatient mental health – office</b>	You pay \$30 copay per visit	You pay 50% Plan pays 50% after the deductible is met
<b>Outpatient substance use disorder – all other services</b>	You pay 10% Plan pays 90%	You pay 50% Plan pays 50%
<b>Outpatient substance use disorder – office</b>	You pay \$30 copay per visit	You pay 50% Plan pays 50% after the deductible is met
<b>Therapy Services</b>		
<b>Outpatient physical therapy</b> <ul style="list-style-type: none"> <li>40 visits per calendar year</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Outpatient speech therapy, hearing therapy and occupational therapy</b> <ul style="list-style-type: none"> <li>40 visits per calendar year</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Chiropractic services</b> <ul style="list-style-type: none"> <li>20 visits per calendar year</li> <li>Unlimited lifetime dollar maximum</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Additional Services</b>		
<b>Family planning</b> <ul style="list-style-type: none"> <li>Excludes elective abortions</li> </ul>	Not Covered	Not Covered
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Includes contraceptive devices as ordered or prescribed by a physician</li> <li>Surgical services such as tubal ligation are covered (excluding reversals)</li> <li>Physician services</li> </ul>	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
<b>TMJ</b>	Not Covered	Not Covered
<b>Organ transplant</b> <ul style="list-style-type: none"> <li>Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities</li> <li>Travel maximum \$10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)</li> </ul>	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility Not Covered

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

## Additional Information

**Selection of a Primary Care Provider-** Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.myCigna.com](http://www.myCigna.com) or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

### Out of Pocket Maximum

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

- Medical copays do not apply towards the out-of-pocket maximum
- Medical deductibles do not apply towards out-of-pocket maximums

### Plan Coverage for Out-of-network Providers

- 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 at 110% of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or supply or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

### Precertification Penalty

Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctor's office. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow the recommended care plan for obtaining pre-treatment authorization for an out-of-network provider, an ineligible expense penalty of \$250 will be applied.

### General Notice of Preexisting Condition Exclusion

- Not applicable

## Exclusions

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

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

### These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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