SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Grand County
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Effective 1/1/2015

General Services	In-Network	Out-of-Network
Physician office visit	Primary care physician You pay $25 copay per visit Specialist You pay $35 copay per visit	You pay 50% Plan pays 50% after the deductible is met
Urgent care visit • All services including Lab & X-ray	Urgent care copay You pay $45	You pay 50% Plan pays 50% after the deductible is met
Preventive Care	Plan pays 100%, no copay, no deductible	Not Covered
Preventive Services	Plan pays 100%, no copay, no deductible	Not Covered
Immunizations	Plan pays 100%, no copay, no deductible	Not Covered
Performance IV Tier pharmacy plan • Includes contraceptives - with specific products covered at 100% • Drugs for which there is an over the counter therapeutic equivalent and lifestyle drugs are covered • 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. This is true even where physician may dictate "Dispense As Written (DAW)" on the prescription • Cigna National Pharmacy Network	Tier 1: $5 copay Tier 2: $25 copay Tier 3: $50 copay Tier 4: 20% with $150 member maximum per 30 day prescription Home Delivery 2.5x Retail 90-Day supply at 3x retail copay	Not Covered
Coinsurance	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Calendar year deductible • In-network and out-of-network expenses do not cross accumulate	Individual $1,000 Family $2,000	Individual $4,000 Family $8,000

General Services	In-Network	Out-of-Network
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums • Pharmacy copays and coinsurance apply towards the out-of-pocket maximums	Individual $4,000 Family $8,000	Individual $12,000 Family $24,000
Lifetime maximum	Unlimited Per individual	
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	Emergency room copay You pay $150	
Ambulance • Unlimited per day maximum	You pay 20% Plan pays 80% after the in-network deductible is met	
Office surgery • Office visit copay applies even if no office visit charges are incurred	Plan pays 100% after office visit copay	You pay 50% Plan pays 50% after the deductible is met
Other office services • 100% after office visit copay • Independent lab paid based on status of the facility	Plan pays 100% after office visit copay	You pay 50% Plan pays 50% after the deductible is met
Outpatient lab and x-ray • Independent Lab and X-ray paid based on status of the facility	Plan pays 100% no deductible	You pay 50% Plan pays 50% after the deductible is met
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Durable medical equipment • Unlimited lifetime maximum • Unlimited annual maximum • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Breast-feeding equipment and supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies	Plan pays 100%, no copay, no deductible	Not Covered

Benefits	In-Network	Out-of-Network
Hospital Services		

Benefits	In-Network	Out-of-Network
Inpatient hospital services • Including anesthesia • $1,000 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services. • Inpatient Lab & X-ray services are subject to the professional service reimbursement	In-network facility You pay 20% Plan pays 80% after the deductible is met	Out-of-network facility You pay $1,000 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
Outpatient hospital services • $1,000 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services. • Outpatient surgery • Including anesthesia • Ambulatory Surgery • Lab & X-Ray paid based on facility network status	Outpatient facility You pay 20% Plan pays 80% after the deductible is met	Outpatient facility You pay $1,000 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
Skilled nursing facility care • 30 days per calendar year maximum	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Hospice care	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Home health care • 60 visits per calendar year maximum	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Mental Health and Chemical Dependency		
Inpatient mental health • $1,000 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.	In-network facility You pay 20% Plan pays 80% after the deductible is met	Out-of-network facility You pay $1,000 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
Inpatient chemical dependency • $1,000 out-of-network per admission deductible is separate and in addition to the plan deductible. Plan deductible only applies to the Professional Services.	In-network facility You pay 20% Plan pays 80% after the deductible is met	Out-of-network facility You pay $1,000 per admission deductible Then You pay 50% Plan pays 50% after the deductible is met
Outpatient mental health	You pay $35 copay	You pay 50% Plan pays 50% after the deductible is met
Outpatient chemical dependency	You pay $35 copay	You pay 50% Plan pays 50% after the deductible is met
Therapy Services		
Outpatient physical therapy • 20 visits per calendar year	You pay $35 copay	You pay 50% Plan pays 50% after the deductible is met

Benefits	In-Network	Out-of-Network
Outpatient speech therapy, hearing therapy and occupational therapy • 20 visits per calendar year	You pay $35 copay	You pay 50% Plan pays 50% after the deductible is met
Chiropractic services • 20 visits per calendar year • Unlimited lifetime dollar maximum	You pay $35 copay	You pay 50% Plan pays 50% after the deductible is met
Acupuncture	Not Covered	Not Covered
Additional Services		
Family planning • Vasectomy • Excludes elective abortions • Includes infertility testing for diagnosis only	Varies based on place of service	Not Covered
Contraceptives • Includes contraceptive devices as ordered or prescribed by a physician • Surgical services such as tubal ligation are covered (excluding reversals) • Physician services	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
TMJ	Not Covered	Not Covered
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility)	In-network facility You pay 20% Plan pays 80% after the deductible is met	Out-of-network facility Not Covered
Out-of-area services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for out of area • Out-of-network deductible and out-of-pocket maximums apply	For all other services You pay 20% Plan pays 80% after the out-of-network deductible is met	

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 or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

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 apply towards the out-of-pocket maximums
- Medical deductibles apply towards the 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.