

SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.



Jewish Theological Seminary, The Open Access Plus – Cigna GOLD POS Plan

General Services	In-Network	Out-of-Network
Physician office visit	Primary care physician You pay \$25 copay per visit Specialist You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Cigna Telehealth Connection services <ul style="list-style-type: none"> 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) Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person. 	You pay \$25 copay per visit	Not Covered
Urgent care visit <ul style="list-style-type: none"> All services including Lab & X-ray 	Urgent care copay You pay \$40	You pay 30% Plan pays 70% after the deductible is met
Preventive Care	Plan pays 100%, no copay, no deductible	You pay 30% Plan pays 70% after the deductible is met
Preventive Services	Plan pays 100%, no copay, no deductible	You pay 30% Plan pays 70% after the deductible is met
Immunizations	Plan pays 100%, no copay, no deductible	You pay 30% Plan pays 70% after the deductible is met
Coinsurance	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Calendar year deductible <ul style="list-style-type: none"> Benefits for an individual within a family are paid once the individual deductible has been met. In-network and out-of-network expenses do not cross accumulate. 	Individual \$500 Family \$1,000	Individual \$2,000 Family \$4,000

General Services	In-Network	Out-of-Network
Out-of-pocket annual maximum <ul style="list-style-type: none"> 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 	Individual \$2,500 Family \$5,000	Individual \$3,500 Family \$7,000
Lifetime maximum	Unlimited Per individual	
Emergency room care <ul style="list-style-type: none"> All services rendered apply to ER benefit including Lab & X-ray 	Emergency room copay You pay \$100	
Ambulance	You pay 10% Plan pays 90% after the in-network deductible is met	
Office surgery	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Other office services <ul style="list-style-type: none"> Independent lab paid based on status of the facility 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Outpatient lab and x-ray <ul style="list-style-type: none"> Independent Lab and X-ray paid based on status of the facility 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Office advanced radiology imaging services <ul style="list-style-type: none"> Includes MRI, MRA, PET, CT-Scan and Nuclear medicine 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Outpatient advanced radiology imaging services <ul style="list-style-type: none"> Includes MRI, MRA, PET, CT-Scan and Nuclear medicine 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Durable medical equipment <ul style="list-style-type: none"> Unlimited lifetime maximum Unlimited annual maximum Includes external prosthetic appliances Does accumulate towards the out-of-pocket maximum 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Breast-feeding equipment and supplies <ul style="list-style-type: none"> 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	You pay 30% Plan pays 70% after the deductible is met

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services <ul style="list-style-type: none"> Including anesthesia Inpatient Lab & X-ray services are subject to the professional service reimbursement 	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay 30% Plan pays 70% after the deductible is met

Benefits	In-Network	Out-of-Network
Outpatient hospital services <ul style="list-style-type: none"> Outpatient surgery Including anesthesia Ambulatory Surgery Lab & X-Ray paid based on facility network status 	Outpatient facility You pay 10% Plan pays 90% after the deductible is met	Outpatient facility You pay 30% Plan pays 70% after the deductible is met
Skilled nursing facility care <ul style="list-style-type: none"> 60 days per calendar year maximum 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Hospice care	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Home health care <ul style="list-style-type: none"> 60 visits per calendar year maximum The limit is not applicable to mental health and substance use disorder conditions. 	You pay 10% Plan pays 90%	You pay 25% Plan pays 75%
Mental Health and Substance Use Disorder		
Inpatient mental health	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay 30% Plan pays 70% after the deductible is met
Inpatient substance use disorder	In-network facility You pay 10% Plan pays 90% after the deductible is met	Out-of-network facility You pay 30% Plan pays 70% after the deductible is met
Outpatient mental health – all other services	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Outpatient mental health – office <ul style="list-style-type: none"> Includes behavioral telehealth consultation 	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Outpatient substance use disorder – all other services	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Outpatient substance use disorder – office <ul style="list-style-type: none"> Includes behavioral telehealth consultation 	You pay \$40 copay per visit	You pay 30% Plan pays 70% after the deductible is met
Therapy Services		
Outpatient physical therapy <ul style="list-style-type: none"> 30 visits per calendar year Limits are not applicable to mental health conditions 	You pay \$40 copay	You pay 30% Plan pays 70% after the deductible is met
Outpatient speech therapy, hearing therapy and occupational therapy <ul style="list-style-type: none"> 30 visits per calendar year Limits are not applicable to mental health conditions for speech and occupational therapies 	You pay \$40 copay	You pay 30% Plan pays 70% after the deductible is met
Chiropractic services <ul style="list-style-type: none"> Unlimited visits per calendar year 	You pay \$40 copay	You pay 30% Plan pays 70% after the deductible is met
Acupuncture	Not Covered	Not Covered
Additional Services		

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Benefits	In-Network	Out-of-Network
Family planning <ul style="list-style-type: none"> Vasectomy Includes elective abortions \$10,000 lifetime maximum on GIFT, ZIFT and InVitro (Injectable infertility drugs are covered under the medical plan instead of the prescription drug plan) 	Varies based on place of service	You pay 30% Plan pays 70% after the deductible is met
Contraceptives <ul style="list-style-type: none"> 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 30% Plan pays 70% after the deductible is met
TMJ <ul style="list-style-type: none"> Unlimited calendar year maximum for surgical and non-surgical treatment 	Varies based on place of service	You pay 30% Plan pays 70% after the deductible is met
Organ transplant <ul style="list-style-type: none"> 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 10% Plan pays 90% after the deductible is met	Out-of-network facility Not Covered
Hearing Aid <ul style="list-style-type: none"> Unlimited maximum per calendar year Includes testing and fitting of hearing aid devices. 	Plan pays 100%	Plan pays 100%
Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Pharmacy Cost Share <ul style="list-style-type: none"> Retail – up to 90-day supply Home Delivery – up to 90-day supply 	Retail (per 30-day supply): Generic: You pay \$10 Preferred Brand: You pay \$30 Non-Preferred Brand: You pay \$50 Retail and Home Delivery (per 90-day supply): Generic: You pay \$25 Preferred Brand: You pay \$75 Non-Preferred Brand: You pay \$125	Retail: You pay 30% Your plan pays 70% Home Delivery: Not Covered
<ul style="list-style-type: none"> Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. 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. When you request a brand drug, you pay the brand 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) (MAC B). You can choose to fill your medications in a 30- or 90-day supply at any network pharmacy. Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits. 		

Drugs Covered

Prescription Drug List:

Your Cigna Advantage Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- 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.
- Non-Sedating Anti-histamines are not covered.
- Oral Fertility drugs are covered.
- Ulcer Drugs (Proton Pump Inhibitors/PPI) are not covered.

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.
- Prior authorization is required on specialty medications and quantity limits may apply.

Pharmacy Cost Management Program

Step Therapy: Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

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.

Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. 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 requirements for obtaining pre-treatment authorization, the lesser of 50% of covered expenses or a \$250 penalty will be applied.

General Notice of Preexisting Condition Exclusion

- Not applicable

Medicare Coordination

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 as permitted by the Social Security Act of 1965** 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.

This plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States

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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EHB State: NY

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 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. 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 LỜI 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 연락해주시고요. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고요.

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 – احرص على الاتصال بـ 1.800.244.6224 (TTY: اتصل بـ 711).
يُصَحَّشُ لِمَكْتَبِطَبِّ رِضِّي لَع نُوْدِمْلَا مَقْرَلَاب لاصتلااء اجرب نيي لاجل Cigna علام عل .مكفل ةحاتم ةني اجملا ةمجرتلل تامدخ هابتنللاء اجرب .

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).

(Farsi) Persian – رد مک یاهرامش اب ٱانفل، Cigna ٱلخف ن اٱرتشم یارب .دوش یم هئارا امش هب ناگوار تروص هب ،ینابز کمک تامدخ :هجوت
ار 711 هرامش :ن اٱاونشان هژبو زفلت هرامش (دیزٱگب سامت 1.800.244.6224 هرامش اب تروصن ن اٱا ریغ رد . دیزٱگب سامت تسامش ی اٱاسانش تتراک تشٱ
(دیزٱک یرٱگهرامش)

