SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

The Parrott Group
Open Access Plus
Plan B

General Services	In-Network	Out-of-Network
Physician office visit – Primary Care Physician (PCP)	You pay $35 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Physician Office Visit – Specialist	You pay $50 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Urgent care visit • All services including Lab & X-ray	You pay $35 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
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
Advantage pharmacy plan • Includes contraceptives • 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) • $150 Individual front end deductible applies to all prescriptions • $300 Family front end deductible applies to all prescriptions • Cigna National Pharmacy Network • 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. • Specialty medications are limited to a 30-day supply • Specialty Drugs provided at Home Delivery at the Retail cost share	**Retail** - (per 30 day supply) Tier 1: $25 Tier 2: $45 Tier 3: $70 **Home Delivery** - (per 90 day supply) 3x Retail Copay less $10 90-day Retail supply at 3x retail copay for Non-Specialty medications after the front end deductible is met	Not Covered
Coinsurance	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%

General Services	In-Network	Out-of-Network
Plan year deductible • 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. • Copays always apply before plan deductible and coinsurance.	Individual: $3,000 Family: $6,000	Individual: $4,000 Family: $8,000
Out-of-pocket annual maximum • Retail and home delivery Pharmacy copays and deductibles contribute to the Combined Medical/Pharmacy out-of-pocket maximum • Pharmacy deductibles apply to the out-of-pocket 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, coinsurance and deductibles apply towards the out-of-pocket maximums	Individual: $6,000 Family: $12,000	Individual: $10,000 Family: $20,000
Lifetime maximum	Unlimited Per individual	
Out-of-network annual maximum		Unlimited Per individual
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	You pay $125 per visit copay (waived if admitted) and 30%, then plan pays 70%	
Ambulance	After the in-network plan deductible is met, You pay 30% Plan pays 70%	
Office surgery – PCP	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Office surgery – Specialist	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Other office services – laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services
Other office services – radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services
Outpatient lab	Plan pays 100%, no deductible	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient radiology	Plan pays 100%, no deductible	After the plan deductible is met, You pay 50% Plan pays 50%
Independent lab	Plan pays 100%, no deductible	After the plan deductible is met, You pay 50% Plan pays 50%

General Services	In-Network	Out-of-Network
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Durable medical equipment • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	After the plan deductible is met, You pay 30% Plan pays 70%	Not Covered
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		
Inpatient hospital services	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient hospital services	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient professional services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Skilled nursing facility care • 100 days per plan year maximum	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Hospice care	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Home health care • 60 visits per plan year maximum	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Mental Health and Substance Use Disorder		
Inpatient mental health • When there is a per admission or per day deductible, the plan deductible (if applicable) will apply only to Professional Services and not to the Facility charges. • Includes Residential Treatment	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, and Group Therapy	You pay $50 copay	After the plan deductible is met, You pay 50% Plan pays 50%

Benefits	In-Network	Out-of-Network
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, and Group Therapy	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Inpatient substance use disorder • When there is a per admission or per day deductible, the plan deductible (if applicable) will apply only to Professional Services and not to the Facility charges. • Includes Residential Treatment	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, and Group Therapy	You pay $50 copay	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient substance use disorder – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, and Group Therapy	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Therapy Services		
Outpatient physical therapy • 20 visits per plan year	After the plan deductible is met, You pay 30% Plan pays 70%	Not Covered
Outpatient speech therapy, hearing therapy and occupational therapy • 40 visits per plan year	After the plan deductible is met, You pay 30% Plan pays 70%	Not Covered
Chiropractic services	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Additional Services		
Medical Specialty Drugs Inpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Medical Specialty Drugs Outpatient Facility • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Medical Specialty Drugs Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
Medical Specialty Drugs Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, You pay 30% Plan pays 70%	After the plan deductible is met, You pay 50% Plan pays 50%
PPACA Women's Health • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices are included.	Plan pays 100%, no copay,no deductible	Not Covered

Benefits	In-Network	Out-of-Network
Family planning • Includes surgical services, such as vasectomy (excludes reversals)	Varies based on place of service	Not Covered
Infertility	Not Covered	Not Covered
Abortion • Includes non-elective procedures • Includes elective procedures in-network only	Varies based on place of service	Varies based on place of service
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)	After the plan deductible is met, You pay 30% Plan pays 70%	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 40% Plan pays 60% 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 plan year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards out-of-pocket maximums
- Deductibles 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 plan year deductible and maximum reimbursable charge limitations.

Precertification Penalty

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, a $250 penalty 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.

EHB State: SC