Summary Of Benefits - Other Covered Benefits

Cigna Health and Life Insurance Co.
For Employees of Lee County Sheriff's Office
Open Access Plus Plan

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.
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. 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.

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.

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.
For children, you may designate a pediatrician as the primary care provider.

Maximum Reimbursable Charge (applies to Non-Participating Providers) - Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage 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 is not used, and the maximum reimbursable charge for covered services is determined 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. 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 co-insurance.

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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.

Benefit	Your cost if you use a		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Lifetime Maximum	Unlimited		
Pre-Existing Condition Limitation (PCL)	Not Applicable		
Calendar Year Deductible	Individual/Person: $300 Family: $600	Individual/Person: $300 Family: $600	• The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles. • After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the co-insurance 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 co-insurance level specified by the plan.
Calendar Year Out-of-Pocket Maximum	Individual/Person: $1,500 Family: $3,000	Individual/Person: $4,000 Family: $6,000	• The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums. • Plan deductible does not contribute toward your out-of-pocket maximum. • Co-pays and benefit deductibles do not contribute towards the out-of-pocket maximum. • Mental health and substance abuse covered expenses contribute towards your out-of-pocket maximum. • 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.

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Benefit	Your cost if you use a		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Routine Preventive Care for Children through age 15	$25 copay per visit for first $300 then you pay 10% coinsurance	50% co-insurance	• Deductibles do not apply
Immunizations for Children through age 15	No Charge	No Charge	• Deductibles do not apply
Routine Preventive Care for age 16 and above	$25 copay per visit for first $300 then you pay 10% coinsurance	50% co-insurance *	
Immunizations for age 16 and above	No charge	50% co-insurance *	
Short-Term Rehabilitation	10% co-insurance *	50% co-insurance *	Per Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 60 days • Cardiac Rehabilitation - 36 days • Chiropractic Care - 20 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum
External Prosthetic Appliances (EPA)	10% co-insurance *	50% co-insurance *	

* - after plan deductible is met

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Place of Service - You pay based on where you receive services.										
	Physician's Office		Outpatient Facility		Emergency Room/ Urgent Care Facility		Independent Lab		Inpatient Hospital Facility	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Lab and X-ray	10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *	10% co-insurance *		10% co-insurance *	50% co-insurance *	Included with Inpatient Hospital charges	Included with Inpatient Hospital charges
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *	10% co-insurance *		Not Applicable	Not Applicable	Included with Inpatient Hospital charges	Included with Inpatient Hospital charges
TMJ, Surgical and Non-Surgical	10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *	Not Applicable		10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *
Unlimited maximum per Lifetime										
Infertility	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.										
Family Planning	10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *	Not Applicable		10% co-insurance *	50% co-insurance *	10% co-insurance *	50% co-insurance *
Includes surgical services, such as tubal ligation or vasectomy (excludes reversals). Contraceptive devices are included.										

* - after plan deductible is met

Benefit	Your cost if you use a		Limitations & Exceptions
	In-Network Provider	Out-of-Network Provider	
Hearing Aids	10% co-insurance *	50% co-insurance *	• $5,000 maximum per Calendar Year
Wigs	10% co-insurance *	50% co-insurance *	• $500 maximum per Calendar Year

* - after plan deductible is met

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What's Not Covered (*not all-inclusive*):
Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Acupuncture
- Cosmetic services
- Custodial and other non-skilled services
- Dental care, unless due to accidental injury to sound natural teeth
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Eyeglass lenses and frames, contact lenses and surgical vision correction
- Genetic screenings
- Infertility Services
- Non-prescription and anti-obesity drugs
- Obesity surgery and services
- Reversal of sterilization procedures
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Services provided through government programs
- Services that are not medically necessary
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit (eVisits)
- Weight loss programs

Summary of Benefits and Coverage Supplement

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