SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Metro Auto Auction, Inc.
Open Access Plus

General Services	In-Network	Out-of-Network
Physician office visit – Primary Care Physician (PCP)	You pay $30 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 $60 per visit copay, then plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Cigna Telehealth Connection services • 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 $30 per visit copay, then plan pays 100%	Not Covered
Urgent care visit • All services including Lab & X-ray	You pay $75 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	After the plan deductible is met, You pay 50% Plan pays 50%
Preventive Services	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 50% Plan pays 50%
Immunizations	Plan pays 100%, no copay, no deductible	After the plan deductible is met, You pay 50% Plan pays 50%
Coinsurance	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Calendar 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: $2,500 Family: $5,000	Individual: $2,500 Family: $5,000

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	Individual: $2,600 Family: $5,200	Individual: $3,750 Family: $7,500
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 $200 per visit copay (waived if admitted), then plan pays 100%	
Ambulance	After the in-network plan deductible is met, You pay 0% Plan pays 100%	
Office surgery – PCP	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Office surgery – Specialist	After the plan deductible is met, You pay 0% Plan pays 100%	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%
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 0% Plan pays 100%	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	You pay $250 copay, then plan pays 100%	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 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
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	After the plan deductible is met, You pay 50% Plan pays 50%

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services	After the plan deductible is met, You pay 0% Plan pays 100%	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 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient hospital services	After the plan deductible is met, You pay 0% Plan pays 100%	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 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Skilled nursing facility care • 60 days per calendar year maximum	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Hospice care	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Home health care	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Mental Health and Substance Use Disorder		
Inpatient mental health • Includes Residential Treatment	After the plan deductible is met, Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $60 copay	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Inpatient substance use disorder • Includes Residential Treatment	After the plan deductible is met, Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	You pay $60 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, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50%
Therapy Services		

Benefits	In-Network	Out-of-Network
Outpatient physical therapy • 20 visits per calendar year • Limits are not applicable to mental health conditions	Covered same as plan's Physician Office Visit – Specialist	After the plan deductible is met, You pay 50% Plan pays 50%
Outpatient speech therapy, hearing therapy and occupational therapy • 20 visits per calendar year • Limits are not applicable to mental health conditions for speech and occupational therapies	Covered same as plan's Physician Office Visit – Specialist	After the plan deductible is met, You pay 50% Plan pays 50%
Chiropractic services	Covered same as Specialist's Office Visit	After the plan deductible is met, You pay 50% Plan pays 50%
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 0% Plan pays 100%	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 0% Plan pays 100%	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 0% Plan pays 100%	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 0% Plan pays 100%	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	Varies based on place of service
Family planning • Includes surgical services, such as vasectomy (excludes reversals) • Includes infertility testing for diagnosis only	Varies based on place of service	Varies based on place of service
Infertility	Not Covered	Not Covered
Abortion • Includes non-elective procedures and elective procedures	Varies based on place of service	Varies based on place of service
TMJ	Not Covered	Not Covered

Benefits	In-Network	Out-of-Network
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum Unlimited (only available if using Cigna LifeSOURCE Transplant Network® facility)	After the plan deductible is met, You pay 0% Plan pays 100%	After the plan deductible is met, You pay 50% Plan pays 50% Transplant Maximums: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Kidney - $80,000 Pancreas - $50,000 Kidney/Pancreas - $80,000 Heart/Lung - $185,000 Lung - $185,000
Pharmacy	**In-Network**	**Out-of-Network**
Cost Share and Supply		
Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) • Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $60 **Retail and Home Delivery (per 90-day supply):** Generic: You pay $30 Preferred Brand: You pay $90 Non-Preferred Brand: You pay $180	**Retail:** You pay 50% Your plan pays 50% **Home Delivery:** Not Covered
• Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. • 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). • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan. • Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.		
Pharmacy Out-of-Pocket Maximum • Retail and Home Delivery cost share applies to the Pharmacy Out-of-Pocket.	Individual: Combined With Medical Family: Combined With Medical	Individual: $1,000 Family: $2,000

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.
- 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, a $750 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)

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Custodial care of a member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or inter-current health care needs. Custodial care includes any skilled or non skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of: walking, transferring or positioning in bed and range of motion exercises; self administered medications; meal preparation and feeding by utensil, tube or gastronomy; oral hygiene, skin and nail care, toilet use, routine enemas; nasal oxygen applications, dressing changes, maintenance of in-dwelling bladder catheters, general maintenance of colostomy ilieostomy, gastronomy, tracheostomy and casts.
- Any unproven or investigational services and supplies, including all related services and supplies. Unproven or investigational services and supplies do not include Routine Patient Services related to approved clinical trials as described in your plan document.
- Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drugs therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of an ongoing phase I, II or III clinical trial, except for Routine Patient Services as provided in the "Clinical Trials" benefit section; or
    - The subject of review or approval by an Institutional Review Board of an academic health institution in the State of Arizona, except for Routine Patient Services as provided in the "Clinical Trials" section of this plan.
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance including Idiopathic Short Stature Syndrome. However, reconstructive surgery and therapy are covered as provided in the “Reconstructive Surgery” section of Covered Expenses.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, except as may be covered under the “Reconstructive Surgery” benefit.
- Treatment of TMJ disorders and craniofacial muscle disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges

Exclusions

made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities or developmental delays.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

Exclusions

- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- For nutritional or dietary supplements, unless those charges are for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non prescribed, except as specifically provided in the "Enteral Nutrition" benefit.
- Charges for an off-label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if: the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature; and the drug has not been determined by the FDA to be contradicted for the specific type of cancer being treated. Coverage will also be provided for any medical services necessary to administer the drug.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges made by a physician/practitioner for broken appointments, phone calls, email or internet evaluations unless otherwise specified in the covered services section of your document.
- Massage therapy.

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: AZ

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 LƯU 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 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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 – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè 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).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).