SCHOOLCARE Orange Open Access

SUMMARY OF BENEFITS

Benefits outlined below are intended as a general summary and are covered only when using a CIGNA participating provider. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. The plan year is defined from July 1 through June 30.

BENEFITS	ORANGE OPEN ACCESS (In-Network Benefits Only)
DEDUCTIBLES, MAXIMUMS* Plan Year Deductible Coinsurance Out-of-Pocket Maximum/Plan Year Maximum Lifetime Benefit * All family members contribute towards family deductible/out-of-pocket max.	 Individual: $2,000; Family: $4,000 Medical 20%; Pharmacy 10% (or $75 cap per prescription) Individual: $4,000; Family: $8,000 Unlimited
EMPLOYER FUNDING Optional subject to collective bargaining or governance policy, the employer may contribute up to 50% of the deductible through an HSA, HRA, FSA or other legally permissible method.	Individual: $1,000; Family: $2,000 **This is the maximum amount allowed annually under SCHOOLCARE policy.**
PREVENTIVE CARE *(Includes Naturopath Services, Routine Laboratory & Diagnostic Testing)* Routine Physical Examination Routine Immunizations Well Child Preventive Care Well Woman Preventive Care Adult Preventive Care Additional services such as urinalysis and EKG Routine Eye Exam (one every 12 months for all ages) Discounts Available for Eyewear	 $0 $0 $0 $0 $0 $0 $0
OTHER PHYSICIAN SERVICES *(Includes Naturopath Services)* Office Visits and/or Office Surgery Maternity Care Cigna Telehealth Connection *(see details on myCigna.com)*	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
OUTPATIENT DIAGNOSTIC TESTING Radiology and Laboratory Services (Prior authorization required for some tests)	Deductible, then 20% to the Out of Pocket Maximum
HOSPITAL CARE Inpatient Services including Newborn Care Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies	Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization)

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BENEFITS	ORANGE OPEN ACCESS (In-Network Benefits Only)
HEARING TESTS	Deductible, then 20% to the Out of Pocket Maximum
EMERGENCY & URGENT CARE *(Medically Necessary and Worldwide)* Hospital Emergency Room Urgent Care Facility	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
MENTAL HEALTH/SUBSTANCE USE DISORDER OUTPATIENT (Physician's office) INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (Prior authorization required)	 Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
PRESCRIPTION DRUGS Through participating pharmacies Certain Preventive Generic Drugs including oral contraceptives (generic), Retail or Maintenance: $0 (Prior authorization required for some drugs)	Retail: (30 day supply) Deductible, then 10% to the Out of Pocket Maximum‡ Maintenance: (90 day supply) Deductible, then 10% to the Out of Pocket Maximum‡ available only through Cigna Home Delivery mail order Specialty Drugs: (30 day supply only) filled through Cigna Home Delivery mail order ‡$75 cap per prescription after deductible
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES OUTPATIENT: short-term rehab, up to 60 days per person/per plan year, includes PT, OT, ST and cardiac rehab (Combined maximum). INPATIENT (Prior authorization required)	Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE 20 days per person/per plan year	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE† *(In or Out of Network)* 12 days per person/per plan year † *Coverage based on Cigna medical guidelines.*	Deductible, then 20% to the Out of Pocket Maximum
DURABLE MEDICAL EQUIPMENT	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS ORAL SURGERY *(accidents only)* REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE *(100 days per person/per plan year maximum)* AMBULANCE *(if not a true emergency, services are not covered)* BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.
GOOD FOR YOU! by SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program	Included