

SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.
For - Pratt Institute
Choice Fund Open Access Plus IN HSA Plan**

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.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Coinsurance	Your plan pays 100%
Calendar Year Deductible	Individual: \$2,000 Family: \$4,000
<ul style="list-style-type: none"> All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan. This plan includes a combined Medical/Pharmacy plan deductible. Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy deductible. 	
Note: Services where plan deductible applies are noted with a caret (^)	
Calendar Year Out-of-Pocket Maximum	Individual: \$2,000 Family: \$4,000
<ul style="list-style-type: none"> Plan deductible contributes towards your out-of-pocket maximum. Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum. All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%. This plan includes a combined Medical/Pharmacy out-of-pocket maximum. Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket. 	

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Benefit

In-Network

Note: Services where plan deductible applies are noted with a caret (^)

Physician Services

Physician Office Visit

- All services including Lab & X-ray

Your plan pays 100% ^

Surgery Performed in Physician's Office

Your plan pays 100% ^

Allergy Treatment/Injections

Your plan pays 100% ^

Allergy Serum

Dispensed by the physician in the office

Your plan pays 100% ^

Cigna Telehealth Connection services

Your plan pays 100% ^

- 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.

Preventive Care

Preventive Care

Your plan pays 100%

- Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.
- Out-of-network preventive care and immunizations are covered at plan coinsurance and deductible through age 18.

Immunizations

Out-of-network preventive care and immunizations are covered at plan coinsurance and deductible through age 18.

Your plan pays 100%

Mammogram, PAP, and PSA Tests

Your plan pays 100%

- Coverage includes the associated Preventive Outpatient Professional Services.
- Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.

Inpatient

Inpatient Hospital Facility

Your plan pays 100% ^

Semi-Private Room: Limited to the semi-private negotiated rate

Private Room: Limited to the semi-private negotiated rate

Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):

Limited to the negotiated rate

Inpatient Hospital Physician's Visit/Consultation

Your plan pays 100% ^

Inpatient Professional Services

- For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists

Your plan pays 100% ^

Outpatient

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Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^)	
Outpatient Facility Services	Your plan pays 100% ^
Outpatient Professional Services	Your plan pays 100% ^
<ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 100% ^
Short-Term Rehabilitation	Your plan pays 100% ^
Calendar Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – Unlimited days Cardiac Rehabilitation - Unlimited days Chiropractic Care - Unlimited days 	
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing subject to medical necessity)	Your plan pays 100% ^
<ul style="list-style-type: none"> 60 days maximum per Calendar Year 16 hour maximum per day 	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility	Your plan pays 100% ^
<ul style="list-style-type: none"> Unlimited days maximum per Calendar Year 	
Durable Medical Equipment	Your plan pays 100% ^
<ul style="list-style-type: none"> Unlimited maximum per Calendar Year 	
Breast Feeding Equipment and Supplies	Your plan pays 100%
<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 	
External Prosthetic Appliances (EPA)	Your plan pays 100% ^
<ul style="list-style-type: none"> Unlimited maximum per Calendar Year 	
Routine Foot Disorders	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	
Hearing Aid	Your plan pays 100% ^
<ul style="list-style-type: none"> Maximum of 1 devices In-Network per 36 months 	

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	In-Network	In-Network	In-Network
Lab and X-ray	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^

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Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	In-Network	In-Network	In-Network
Advanced Radiology Imaging	Plan pays 100% ^	Not Applicable	Plan pays 100% ^	Plan pays 100% ^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc...

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
	In-Network	In-Network	In-Network
Emergency Care	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
Urgent Care	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	In-Network	In-Network
Hospice	Plan pays 100% ^	Plan pays 100% ^
Bereavement Counseling	Plan pays 100% ^	Plan pays 100% ^

Note: Services provided as part of Hospice Care Program

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	In-Network	In-Network	In-Network	In-Network
Maternity	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network

Note: Services where plan deductible applies are noted with a caret (^)

Abortion (Elective and non-elective procedures)	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
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Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
Note: Services where plan deductible applies are noted with a caret (^)					
Family Planning - Men's Services	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.					
Infertility	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Injectable infertility drugs are covered under the medical plan instead of the prescription drug plan. Unlimited lifetime maximum					
TMJ, Surgical and Non-Surgical	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Unlimited maximum per lifetime					
Benefit	Inpatient Hospital Facility		Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	
Organ Transplants	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^	
<ul style="list-style-type: none"> Travel Maximum - Lifesource Facility: Unlimited 					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	Inpatient In-Network	Outpatient - Physician's Office In-Network	Outpatient - All Other Services In-Network		
Mental Health	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^		
Substance Use Disorder	Plan pays 100% ^	Plan pays 100% ^	Plan pays 100% ^		
Note: Services where plan deductible applies are noted with a caret (^)					
Note: Detox is covered under medical					
<ul style="list-style-type: none"> Unlimited maximum per Calendar Year Services are paid at 100% after you reach your out-of-pocket maximum. Inpatient includes Residential Treatment. Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy. 					

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Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy

In-Network

Out-of-Network

Cigna Pharmacy three-tier copay plan

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Patient is responsible for the applicable copay based upon the tier of the dispensed medication.
- Your pharmacy benefits have a combined annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- Self Administered injectable drugs are covered
- Oral contraceptives included
- Includes oral contraceptives - with specific products covered 100%
- Oral Fertility drugs included
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included
- Specialty medications are limited to a 90-day supply for Home Delivery
- Specialty medications are limited to a 30-day supply at Retail

Retail - 30 day supply

Generic: You pay \$15
Preferred Brand: You pay \$30
Non-Preferred Brand: You pay \$50

Home delivery - 90 day supply

Generic: You pay \$30
Preferred Brand: You pay \$60
Non-Preferred Brand: You pay \$100

Not Covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

Prescription Drug List:

- Your Cigna Legacy Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

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Pharmacy Program Information

Specialty Pharmacy Management:

- Clinical Programs
 - Prior authorization is required on specialty medications but quantity limits may apply.
 - Theracare® Program
- Medication Access Option
 - Retail and/or Home Delivery

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program

- Care Management outreach
- Case Management

Included

Health Advisor - A

Support for healthy and at-risk individuals to help them stay healthy

- Health and Wellness Coaching
- Gaps in Care coaching for select conditions
- Preference Sensitive Care/Treatment Decision Support Coaching

Included

Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

\$150 (1st trimester) / \$75 (2nd trimester) - Option 3

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions

In Network: Coordinated by your physician

Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing

In Network: Coordinated by your physician

Pre-Existing Condition Limitation (PCL) does not apply.

Additional Information

Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.
- Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- Treatment provided in a government hospital.

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Exclusions

- Benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law.
- Services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- Services performed by a member of the covered person's immediate family.
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- Hearing aids.
- Eyeglasses and examination for the prescription or fitting thereof.
- Rest cures and custodial care.
- Expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

Exclusions and Expenses Not Covered Unless Medically Necessary

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from 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.
- 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.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Dental implants for any condition.
- For or in connection with experimental, investigational or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or noninvestigational treatments provided in such clinical trial.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
 - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
 - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
 - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Charges made for drugs and implanted/injected devices for contraception.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any

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Exclusions

symptoms or any significant, proven risk factors for genetically linked inheritable disease.

- 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.

Limitations of Coverage

No payment will be made for expenses incurred for you or any one of your Dependents:

- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.
- To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which would not have been made if the person had no insurance.
- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

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.

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