Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
MEDICAL PLAN PROVISIONS	**Do Services Require Prior AuthorizB5:F6ation?**				
Annual Medical Deductible (Per Person / Per Family)		$500 / $1,500	$1,000 / $3,000	$1,000 / $3,000	$2,000 / $6,000
Annual Medical Out of Pocket Maximum (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.		$1,000 / $3,000	$2,000 / $6,000	$2,000 / $6,000	$4,000 / 12,000
Amounts in Excess of Negotiated Rates/ Reasonable and Allowed Amounts		For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.
Lifetime Maximum		None	None	None	None
Dependent Coverage		26		26	
Medical Services					
Physician Services					
Primary Care Office Visits	NO	$10 Copayment per visit	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$20 Copayment per visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Specialist Care Office Visits	NO	$10 Copayment per visit	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$20 Copayment per visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Other Physician Services performed in the office-including Diagnostic Services, Office Surgery and Radiology Services.	NO	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	NO	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Urgent Care	NO	$20 Copayment per visit	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$30 Copayment per visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Maternity					
Physician Services (Office Visits)	NO	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Preventive Care					
Benefits for Children					
New Born Circumcision	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "Well-child visits) 5 to 17 (1 per year, "Well-child Visit")	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Well Child Care Immunization (as Recommended by Bright Futures project)	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Well Child Lab Test (as Recommended by Bright Futures project)	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Adult Preventive Care Screening/Testing					
Adults, One (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Immunization Services for Adults Immunizations - does, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Prostate Specific Antigen (Men, One per CY, age 50 and under)	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Screenings such as; obesity, blood pressure, cholesterol, cancer, HIV, Alcohol Misuse	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Counseling such as; alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, Tobacco use.	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Woman's Preventive Care Services					
Prescribed contraceptive methods, sterilization procedures and patient education, (supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - Birth control pills, Diaphragms, emergency contraceptive pill through your pharmacy Benefits).	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Well Woman Exam per benefit year to obtain recommended preventive and diagnostic services (subject to all Limitations as described under Covered Medical Benefits)	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Services for Pregnant Woman including but not limited to Anemia Screening, Rh Incompatibility Screenings, Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breast-feeding supplies, for pregnant and nursing women. (Reimbursement of Non-participating breastfeeding supplies up to the amount of $200).	NO	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital/Facilities Services					
Inpatient Room & Care (semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)	Yes	$100 Copayment/Day up to Three Days	$100 Copayment/Day up to Three Days Plus amounts that exceed the Reasonable and Allowed Amount	$150 Copayment per Day up to Three Days after annual deductible	150 Copayment per Day up to Three Days after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Outpatient / Ambulatory Surgery Services & Birthing Centers	Yes	$100 Copayment after Annual Deductible (waived if admitted to Inpatient status)	$100 Copayment after Annual Deductible, plus amounts that exceed the Reasonable & Allowed Amount (waived if admitted to Inpatient status)	$150 Copayment after annual deductible	$150 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Other Outpatient hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Emergency Room Services	No	$100 Copayment after Annual Deductible (waived if admitted to Inpatient status)	$100 Copayment after Annual Deductible, plus amounts that exceed the Reasonable & Allowed Amount (waived if admitted to Inpatient status)	$150 Copayment (waived if admitted to inpatient)	$150 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Diagnostic Services					

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Laboratory Services					
Non Hospital based	No (Except for Genetic testing)	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Radiology & and Radiation Oncology Services					
Non Hospital based	No	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
CT/MRI/MRA/PET Scan					
Non Hospital based	Yes	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Mental Health/Behavioral Health/Substance Abuse Disorder					
Inpatient					
Hospital/Facilities Services; semi-private room rate	Yes	$100 Copayment per Day up to Three Days after Annual Deductible	$100 Copayment per Day up to Three Days after Annual Deductible, plus amounts that exceed the Reasonable & Allowed Amount	$150 Copayment per Day up to Three Days after annual deductible	$150 Copayment per Day up to Three Days after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Psychiatrist & Psychologist Services	No	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible. Plus amounts that exceed the Reasonable and Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Outpatient					
Psychiatrist & Psychologist Services	Yes (if at a Hospital)	$10 Copayment per visit	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$20 Copayment per visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Psychological Testing	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Other Services					
Allergy Testing (including serum, injections, and administration)	No	$10 copayment per visit	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$20 Copayment per visit	15%* Plus amounts that exceed the Reasonable and Allowed Amount

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Ground Ambulance	Yes (Non-emergent)	$150 Copayment after Annual Deductible	$150 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$200 Copayment after annual deductible	$200 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Air Ambulance	Yes (Non-emergent)	$150 Copayment after Annual Deductible	$150 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$200 Copayment after annual deductible	$200 Copayment after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Chemotherapy	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Dialysis and Supplies	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Durable medical Equipment (including Orthotics/prosthetics)	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Enteral Nutrition Therapy	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hearing Aids(Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	No	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Evaluations for the Use of Hearing Aids	No	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Home Health Services (Maximum of 120 visits per year)	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Home Infusion Services	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospice Services	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30 Copayment per Visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Human Growth Hormone, Genetic Testing/Counseling, Other	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	15% Coinsurance after Annual Deductible	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Physical/Occupational Therapy	Yes (after initial 5 Visits)	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Speech Therapy	Yes	10% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
ALTERNATIVE CARE SERVICES					
There is a combined benefit year benefit maximum of $400.00 paid by the Plan for Alternative Care Services					
Acupuncture	No	$20 copayment per visit	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Chiropractic Care	No	$20 copayment per visit	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Naturopathy	No	$20 copayment per visit	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Massage Therapy	No	$20 copayment per visit	30% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$30 copayment per visit	40% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
VISION PLAN PROVISIONS					
Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery In Lieu Of Glasses		$250 per year, per covered member		$250 per year, per covered member	
PHARMACY PROVISIONS (Please refer to Member ID Card for Pharmacy Contact Information		**Member Pays**		**Member Pays**	
PHARMACY BENEFITS		**Participating Pharmacies**	**Non-Participating Pharmacies**	**Participating Pharmacies**	**Non-Participating Pharmacies**
Annual Pharmacy Deductible (If applicable will display as Per Person / Per Family)		None	Not Applicable	None	Not Applicable
Annual Pharmacy Out of Pocket Maximum (If Pharmacy OOP Maximum is Separate from the Medical OOP Maximum will display as Per Person / Per Family)		$5,850 / $10,700	Not Applicable	$4,850 / $7,700	Not Applicable
Lifetime Maximum					
Preventive Prescription Services					
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.					
Prescription Drugs Pharmacy Retail - up to a 31 Day supply		Generic Only - $0	Not Covered	Generic Only - $0	Not Covered
Non-Preventive Prescription Drugs					
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.					
Pharmacy Retail – up to a 31 Day supply (Generic, Preferred, Non-preferred)		Generic - $10 Copayment Preferred Brand - $20 Copayment on-Preferred Brand - $35 Copayment	Not Covered	Generic - $20 Copayment Preferred Brand - $30 Copayment on-Preferred Brand - $45 Copayment	Not Covered

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**		**PPO PREMIUM (CIGNA)**		**PPO PREFERRED (CIGNA)**	
		Member Pays		**Member Pays**	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Prescription Drugs Pharmacy Retail - 90 Day Supply		Generic - $30 Copayment Preferred Brand - $60 Copayment on-Preferred Brand - $105 Copayment	Not Covered	Generic - $60 Copayment Preferred Brand - $90 Copayment on-Preferred Brand - $135 Copayment	Not Covered
Prescription Drugs Pharmacy Mail Order - 90 Day Supply		Generic - $20 Copayment Preferred Brand - $40 Copayment on-Preferred Brand - $70 Copayment	Not Covered	Generic - $40 Copayment preferred Brand - $60 Copayment on-Preferred Brand - $90 Copayment	Not Covered
Specialty Drug		Generic - $10 Copayment Preferred Brand - $20 Copayment on-Preferred Brand - $35 Copayment	Not Covered	Generic - $20 Copayment Preferred Brand - $30 Copayment on-Preferred Brand - $45 Copayment	Not Covered

Monthly Cost
Employee Only
Employee + Spouse
Employee + Child(ren)
Family

*Coinsurance amount is based on an approved *Reasonable and Allowed* reimbursement level.

***Precertification* is required for this service.

***After Plan Deductible

Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable & Allowed reimbursement level for Non-Participating Providers as established by the Plan.

Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

In Network: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

Out of Network: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
MEDICAL PLAN PROVISIONS				
Annual Medical Deductible (Per Person / Per Family)	$2,000 / $6,000	$4,000 / $12,000	$1,350 / $2,700	$5,000 / $10,000
Annual Medical Out of Pocket Maximum (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.	$4,000 / $12,000	$8,000 / $24,000	$3,000 / $6,000	$5,000 / $10,000
Amounts in Excess of Negotiated Rates/ Reasonable and Allowed Amounts	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.
Lifetime Maximum	None	None	None	None
Dependent Coverage	26		26	
Medical Services				
Physician Services				
Primary Care Office Visits	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Specialist Care Office Visits	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Other Physician Services performed in the office-including Diagnostic Services, Office Surgery and Radiology Services.	20% Coinsurance After Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Urgent Care	$35 Copayment per Visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$35 Copayment per Visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Maternity				
Physician Services (Office Visits)	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Preventive Care				
Benefits for Children				
New Born Circumcision	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "Well-child visits) 5 to 17 (1 per year, "Well-child Visit")	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Child Care Immunization (as Recommended by Bright Futures project)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Well Child Lab Test (as Recommended by Bright Futures project)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Adult Preventive Care Screening/Testing				
Adults, One (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Immunization Services for Adults Immunizations - does, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Prostate Specific Antigen (Men, One per CY, age 50 and under)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Screenings such as; obesity, blood pressure, cholesterol, cancer, HIV, Alcohol Misuse	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Counseling such as; alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, Tobacco use.	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Woman's Preventive Care Services				
Prescribed contraceptive methods, sterilization procedures and patient education, (supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - Birth control pills, Diaphragms, emergency contraceptive pill through your pharmacy Benefits).	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Woman Exam per benefit year to obtain recommended preventive and diagnostic services (subject to all Limitations as described under Covered Medical Benefits)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Services for Pregnant Woman including but not limited to Anemia Screening, Rh Incompatibility Screenings, Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breast-feeding supplies, for pregnant and nursing women. (Reimbursement of Non-participating breastfeeding supplies up to the amount of $200).	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospital/Facilities Services				
Inpatient Room & Care (semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)	$200 Copayment per day up to Three Days	$200 Copayment per Day up to Three Days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$150 Copayment per day up to Three Days	$150 Copayment per Day up to Three Days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Outpatient / Ambulatory Surgery Services & Birthing Centers	$200 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$200 Copayment Plus amounts that exceed the Reasonable and Allowed Amount	$200 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$200 Copayment Plus amounts that exceed the Reasonable and Allowed Amount
Other Outpatient hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	20% Coinsurance after Annual Deductible(waived if admitted to Inpatient status)	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Emergency Room Services	$200 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$200 Copayment Plus amounts that exceed the Reasonable and Allowed Amount	$200 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$200 Copayment Plus amounts that exceed the Reasonable and Allowed Amount
Diagnostic Services				

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Laboratory Services				
Non Hospital based	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Radiology & and Radiation Oncology Services				
Non Hospital based	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
CT/MRI/MRA/PET Scan				
Non Hospital based	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Hospital based	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount
Mental Health/Behavioral Health/Substance Abuse Disorder				
Inpatient				
Hospital/Facilities Services; semi-private room rate	$200 Copayment after annual Deductible up to Three days	$200 Copayment after annual Deductible up to Three days Plus amounts that exceed the Reasonable and Allowed Amount	$150 Copayment after annual Deductible up to Three days	$150 Copayment after annual Deductible up to Three days Plus amounts that exceed the Reasonable and Allowed Amount
Psychiatrist & Psychologist Services	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	20% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Outpatient				
Psychiatrist & Psychologist Services	$25 Copayment per visit	50%* Plus amounts that exceed the Reasonable and Allowed Amount	$25 Copayment per visit	50%* Plus amounts that exceed the Reasonable and Allowed Amount
Psychological Testing	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible. Preauthorization is required if at hospital. If you don't get preauthorization, benefits could be reduced by 25%.*	20% Coinsurance, after Annual Deductible.	50% Coinsurance after Annual Deductible. Preauthorization is required if at hospital. If you don't get preauthorization, benefits could be reduced by 25%.*
Other Services				
Allergy Testing (including serum, injections, and administration)	$25 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$25 Copayment per visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Ground Ambulance	$250 Copayment after Annual Deductible	$250 Copayment Plus amounts that exceed the Reasonable and Allowed Amount	$250 Copayment after Annual Deductible	$250 Copayment Plus amounts that exceed the Reasonable and Allowed Amount
Air Ambulance	$250 Copayment after Annual Deductible	$250 Copayment after Annual Deductible, plus amounts that exceed the Reasonable & Allowed Amount	$250 Copayment after Annual Deductible	$250 Copayment after Annual Deductible, plus amounts that exceed the Reasonable & Allowed Amount
Chemotherapy	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Dialysis and Supplies	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Durable medical Equipment (including Orthotics/prosthetics)	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Enteral Nutrition Therapy	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Hearing Aids(Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Evaluations for the Use of Hearing Aids	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Home Health Services (Maximum of 120 visits per year)	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Home Infusion Services	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Hospice Services	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Human Growth Hormone, Genetic Testing/Counseling, Other	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	20% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Physical/Occupational Therapy	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Speech Therapy	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
ALTERNATIVE CARE SERVICES				
There is a combined benefit year benefit maximum of $400.00 paid by the Plan for Alternative Care Services				
Acupuncture	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible is met, plus amounts that exceed the Reasonable and Allowed Amount
Chiropractic Care	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible is met, plus amounts that exceed the Reasonable and Allowed Amount
Naturopathy	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible is met, plus amounts that exceed the Reasonable and Allowed Amount
Massage Therapy	$35 copayment per visit	50% Coinsurance after Annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount	$35 copayment per visit	50% Coinsurance after Annual Deductible is met, plus amounts that exceed the Reasonable and Allowed Amount
VISION PLAN PROVISIONS				
Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery In Lieu Of Glasses	$250 per year, per covered member		$250 per year, per covered member	
PHARMACY PROVISIONS (Please refer to Member ID Card for Pharmacy Contact Information	**Member Pays**		**Member Pays**	
PHARMACY BENEFITS	**Participating Pharmacies**	**Non-Participating Pharmacies**	**Participating Pharmacies**	**Non-Participating Pharmacies**
Annual Pharmacy Deductible (If applicable will display as Per Person / Per Family)	None	Not Applicable	Combined with Medical Annual Deductible	Not Applicable
Annual Pharmacy Out of Pocket Maximum (If Pharmacy OOP Maximum is Separate from the Medical OOP Maximum will display as Per Person / Per Family)	$1,700 / $1,700	Not Applicable	Combined with the Medical Annual Out of Pocket Maximum	Not Applicable
Lifetime Maximum				
Preventive Prescription Services				
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.				
Prescription Drugs Pharmacy Retail - up to a 31 Day supply	Generic Only - $0	Not Covered	Generic Only - $0	Not Covered
Non-Preventive Prescription Drugs				
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.				
Pharmacy Retail – up to a 31 Day supply (Generic, Preferred, Non-preferred)	Generic - $25 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $55 Copayment	Not Covered	Generic - $25 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $55 Copayment	Not Covered

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO GOLD (CIGNA)**		**PPO GOLD H.S.A (CIGNA)**	
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Prescription Drugs Pharmacy Retail - 90 Day Supply	Generic - $75Copayment Preferred Brand - $120Copayment Non-Preferred Brand - $165 Copayment	Not Covered	Generic - $75Copayment Preferred Brand - $120Copayment Non-Preferred Brand - $165 Copayment	Not Covered
Prescription Drugs Pharmacy Mail Order - 90 Day Supply	Generic - $50 Copayment Preferred Brand - $80 Copayment Non-Preferred Brand - $110 Copayment	Not Covered	Generic - $50 Copayment Preferred Brand - $80 Copayment Non-Preferred Brand - $110 Copayment	Not Covered
Specialty Drug	Generic - $25 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $55 Copayment	Not Covered	Generic - $25 Copayment Preferred Brand - $40 Copayment Non-Preferred Brand - $55 Copayment	Not Covered

Monthly Cost
Employee Only
Employee + Spouse
Employee + Child(ren)
Family

*Coinsurance amount is based on an approved *Reasonable and Allowed* reimbursement level.

***Precertification* is required for this service.

***After Plan Deductible

Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable & Allowed reimbursement level for Non-Participating Providers as established by the Plan.

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

In Network: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements

Out of Network: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
MEDICAL PLAN PROVISIONS				
Annual Medical Deductible (Per Person / Per Family)	$2,000 / $6,000	$4,000 /$12,000	$5,000 / $10,000	$5,000 / $10,000
Annual Medical Out of Pocket Maximum (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.	$6,600 / $13,200	$8,000 / $24,000	$6,250 / $12,500	$6,250 / $12,500
Amounts in Excess of Negotiated Rates/ Reasonable and Allowed Amounts	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.
Lifetime Maximum	None	None	None	None
Dependent Coverage	26		26	26
Medical Services				
Physician Services				
Primary Care Office Visits	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Specialist Care Office Visits	$25 Copayment per visit after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Other Physician Services performed in the office-including Diagnostic Services, Office Surgery and Radiology Services.	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Urgent Care	$50 Copayment per Visit	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Maternity				
Physician Services (Office Visits)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Preventive Care				
Benefits for Children				
New Born Circumcision	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "Well-child visits) 5 to 17 (1 per year, "Well-child Visit")	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Well Child Care Immunization (as Recommended by Bright Futures project)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
Well Child Lab Test (as Recommended by Bright Futures project)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Adult Preventive Care Screening/Testing				
Adults, One (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Immunization Services for Adults Immunizations - does, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Prostate Specific Antigen (Men, One per CY, age 50 and under)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Screenings such as; obesity, blood pressure, cholesterol, cancer, HIV, Alcohol Misuse	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Counseling such as; alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, Tobacco use.	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Woman's Preventive Care Services				
Prescribed contraceptive methods, sterilization procedures and patient education, (supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - Birth control pills, Diaphragms, emergency contraceptive pill through your pharmacy Benefits).	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Well Woman Exam per benefit year to obtain recommended preventive and diagnostic services (subject to all Limitations as described under Covered Medical Benefits)	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Services for Pregnant Woman including but not limited to Anemia Screening, Rh Incompatibility Screenings, Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breast-feeding supplies, for pregnant and nursing women. (Reimbursement of Non-participating breastfeeding supplies up to the amount of $200).	No Copayment	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	No Copayment	No Copayment
Hospital/Facilities Services				
Inpatient Room & Care (semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Outpatient / Ambulatory Surgery Services & Birthing Centers	$400 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$400 Copayment Plus amounts that exceed the Reasonable and Allowed Amount (Copayment waived if admitted to Inpatient status)	30% Coinsurance after Annual Deductible(waived if admitted to Inpatient status)	30% Coinsurance after Annual Deductible(waived if admitted to Inpatient status)
Other Outpatient hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	30% Coinsurance After Annual Deductible(Copayment waived if admitted to Inpatient status)	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible(waived if admitted to Inpatient status)	30% Coinsurance after Annual Deductible(waived if admitted to Inpatient status)
Emergency Room Services	$500 Copayment (Waved if admitted to Inpatient Status)	$500 Copayment Plus amounts that exceed the Reasonable and Allowed Amount (Copayment waived if admitted to Inpatient status)	$300 Copayment after Annual Deductible(waived if admitted to Inpatient status)	$300 Copayment after Annual Deductible(waived if admitted to Inpatient status)
Diagnostic Services				

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
Laboratory Services				
Non Hospital based	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Hospital based	50% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Radiology & and Radiation Oncology Services				
Non Hospital based	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Hospital based	50% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
CT/MRI/MRA/PET Scan				
Non Hospital based	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Hospital based	50% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Mental Health/Behavioral Health/Substance Abuse Disorder				
Inpatient				
Hospital/Facilities Services; semi-private room rate	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Psychiatrist & Psychologist Services	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Outpatient				
Psychiatrist & Psychologist Services	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Psychological Testing	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Other Services				
Allergy Testing (including serum, injections, and administration)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
Ground Ambulance	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$300 Copayment*	$300 Copayment*
Air Ambulance	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$300 Copayment*	$300 Copayment*
Chemotherapy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Dialysis and Supplies	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Durable medical Equipment (including Orthotics/prosthetics)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Enteral Nutrition Therapy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Hearing Aids(Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Evaluations for the Use of Hearing Aids	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Home Health Services (Maximum of 120 visits per year)	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Home Infusion Services	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible
Hospice Services	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Human Growth Hormone, Genetic Testing/Counseling, Other	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	30% Coinsurance after Annual Deductible	30% Coinsurance after Annual Deductible

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
Physical/Occupational Therapy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
Speech Therapy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	$60 Copayment per visit, after Annual Deductible	$60 Copayment per visit, after Annual Deductible
ALTERNATIVE CARE SERVICES				
There is a combined benefit year benefit maximum of $400.00 paid by the Plan for Alternative Care Services				
Acupuncture	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Not Covered	Not Covered
Chiropractic Care	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Not Covered	Not Covered
Naturopathy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Not Covered	Not Covered
Massage Therapy	30% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Not Covered	Not Covered
VISION PLAN PROVISIONS				
Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery In Lieu Of Glasses	$250 per year, per covered member		$250 per year, per covered member	$250 per year, per covered member
PHARMACY PROVISIONS (Please refer to Member ID Card for Pharmacy Contact Information	**Member Pays**		**Member Pays**	**Member Pays**
PHARMACY BENEFITS	**Participating Pharmacies**	**Non-Participating Pharmacies**		
Annual Pharmacy Deductible (If applicable will display as Per Person / Per Family)	None	Not Applicable	None	Combined with Medical Annual Deductible
Annual Pharmacy Out of Pocket Maximum (If Pharmacy OOP Maximum is Separate from the Medical OOP Maximum will display as Per Person / Per Family)	Combined with the Medical Annual Out of Pocket Maximum Medical MOOP: $6,600 Per Person / $13,200 Per Family	Not Applicable	Combined with the Medical Annual Out of Pocket Maximum Medical MOOP: $6250 per person/ $1200 Per family	Combined with the Medical Annual Out of Pocket Maximum Medical MOOP: $6250 per person/ $1200 Per family
Lifetime Maximum				
Preventive Prescription Services				
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.				
Prescription Drugs Pharmacy Retail - up to a 31 Day supply	Generic Only - $0	Not Covered	Generic Only - $0	Generic Only - $0
Non-Preventive Prescription Drugs				
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.				
Pharmacy Retail – up to a 31 Day supply (Generic, Preferred, Non-preferred)	Generic - $25 Copayment Preferred Brand - $50 Copayment Non-Preferred Brand - $75 Copayment	Not Covered	Generic - $15 Copayment Preferred Brand - $50 Copayment Non-Preferred Brand - $65 Copayment	Generic - $15 Copayment Preferred Brand - $50 Copayment Non-Preferred Brand - $65 Copayment

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**PPO BRONZE LEVEL 1 (CIGNA)**		**EPO BRONZE LEVEL 2 (CIGNA)**	**EPO BRONZE LEVEL 2, WITH H.S.A. (CIGNA)**
	Member Pays		**Member Pays**	
	In Network	**Out of Network**	**In Network**	**In Network**
Prescription Drugs Pharmacy Retail - 90 Day Supply	Generic - $75Copayment Preferred Brand - $150Copayment Non- Preferred Brand - $225 Copayment	Not Covered	Generic - $45 Copayment Preferred Brand - $150Copayment Non- Preferred Brand - $195 Copayment	Generic - $45 Copayment Preferred Brand - $150Copayment Non- Preferred Brand - $195 Copayment
Prescription Drugs Pharmacy Mail Order - 90 Day Supply	Generic - $50 Copayment Preferred Brand - $100 Copayment Non- Preferred Brand - $150 Copayment	Not Covered	Generic - $30 Copayment Preferred Brand - $100 Copayment Non- Preferred Brand - $130 Copayment	Generic - $30 Copayment Preferred Brand - $100 Copayment Non- Preferred Brand - $130 Copayment
Specialty Drug	Generic - $25 Copayment Preferred Brand - $50 Copayment Non- Preferred Brand - $75 Copayment	Not Covered	Generic - $15 Copayment Preferred Brand - $50 Copayment Non- Preferred Brand - $65 Copayment	Generic - $15 Copayment Preferred Brand - $50 Copayment Non- Preferred Brand - $65 Copayment

Monthly Cost
Employee Only
Employee + Spouse
Employee + Child(ren)
Family

*Coinsurance amount is based on an approved *Reasonable and Allowed* reimbursement level.

***Precertification* is required for this service.

***After Plan Deductible

Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable & Allowed reimbursement level for Non-Participating Providers as established by the Plan.

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

In Network: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements

Out of Network: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	**Member Pays**	**Member Pays**	
	In Network	**In Network**	**In Network**	**Out of Network**
MEDICAL PLAN PROVISIONS				
Annual Medical Deductible (Per Person / Per Family)	None	None	$3,000 / $6,000	$6,000 / $12,000
Annual Medical Out of Pocket Maximum (Per Person / Per Family) The Member's Deductible, Copayments, and Coinsurance apply to the Annual Out-of-Pocket Maximum.	$3,000 / $6,000	$1,500 / $3,000	$3,000 / $6,000	$12,000 / $24,000
Amounts in Excess of Negotiated Rates/ Reasonable and Allowed Amounts	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Participating Providers, the contract generally prohibits the provider from charging more than the Reasonable & Allowed amount for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.	For Non-Participating Providers, the member will be responsible for the deductible, copayments, and coinsurance, as well as any amounts exceeding the Reasonable & Allowed amount. Any amounts in excess of the Reasonable & Allowed amount payable to Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.
Lifetime Maximum	None	None	None	None
Dependent Coverage	26	26	26	
Medical Services				
Physician Services				
Primary Care Office Visits	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Specialist Care Office Visits	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Other Physician Services performed in the office-including Diagnostic Services, Office Surgery and Radiology Services.	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Physician Services in a Facility (Hospital, Outpatient Surgery, Emergency Room)	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Urgent Care	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Maternity				
Physician Services (Office Visits)	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Preventive Care				
Benefits for Children				
New Born Circumcision	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Child Care Office Visits 0 to 11 months (6 "well-baby visits") 1 to 4 years (7 "Well-child visits) 5 to 17 (1 per year, "Well-child Visit")	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Child Care Immunization (as Recommended by Bright Futures project)	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	**Member Pays**	**Member Pays**	
	In Network	**In Network**	**In Network**	**Out of Network**
Well Child Lab Test (as Recommended by Bright Futures project)	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Adult Preventive Care Screening/Testing				
Adults, One (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Immunization Services for Adults Immunizations - does, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Prostate Specific Antigen (Men, One per CY, age 50 and under)	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Screenings such as; obesity, blood pressure, cholesterol, cancer, HIV, Alcohol Misuse	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Counseling such as; alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, Tobacco use.	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Woman's Preventive Care Services				
Prescribed contraceptive methods, sterilization procedures and patient education, (supply and administration of Contraceptive IUDs, Implants and Injectables). (Pharmacy - Birth control pills, Diaphragms, emergency contraceptive pill through your pharmacy Benefits).	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Well Woman Exam per benefit year to obtain recommended preventive and diagnostic services (subject to all Limitations as described under Covered Medical Benefits)	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Services for Pregnant Woman including but not limited to Anemia Screening, Rh Incompatibility Screenings, Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breast-feeding supplies, for pregnant and nursing women. (Reimbursement of Non-participating breastfeeding supplies up to the amount of $200).	No Copayment	No Copayment	No Copayment	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospital/Facilities Services				
Inpatient Room & Care (semi-private room rate (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting)	$500 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Outpatient / Ambulatory Surgery Services & Birthing Centers	$250 Copayment per Visit (waived if Admitted to Inpatient Status)	$20 Copayment per Visit (waived if Admitted to Inpatient Status)	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Other Outpatient hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	$50 Copayment per Visit (waived if Admitted to Inpatient Status)	$20 Copayment per Visit (waived if Admitted to Inpatient Status)	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Emergency Room Services	$100 Copayment per Visit (waived if Admitted to Inpatient Status)	$100 Copayment per Visit (waived if Admitted to Inpatient Status)	$100 Copayment After Annual Deductible(Copayment waived if admitted to Inpatient status)	$100 Copayment After annual Deductible Plus amounts that exceed the Reasonable and Allowed Amount
Diagnostic Services				

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	**Member Pays**	**Member Pays**	
	In Network	**In Network**	**In Network**	**Out of Network**
Laboratory Services				
Non Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Radiology & and Radiation Oncology Services				
Non Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
CT/MRI/MRA/PET Scan				
Non Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospital based	$50 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Mental Health/Behavioral Health/Substance Abuse Disorder				
Inpatient				
Hospital/Facilities Services; semi-private room rate	$500 Copayment	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Psychiatrist & Psychologist Services	$40 Copayment per visit	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Outpatient				
Psychiatrist & Psychologist Services	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Psychological Testing	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Other Services				
Allergy Testing (including serum, injections, and administration)	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	Member Pays	Member Pays	
	In Network	In Network	In Network	Out of Network
Ground Ambulance	$150 Copayment	$50 Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Air Ambulance	$150 Copayment	$50 Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Chemotherapy	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Dialysis and Supplies	$40 Copayment per visit	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Durable medical Equipment (including Orthotics/prosthetics)	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Enteral Nutrition Therapy	$40 Copayment per visit	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hearing Aids(Limited to one (1) device per ear every five (5) years) Maximum of $1,500 per covered device	$40 Copayment per visit	No Copayment	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Evaluations for the Use of Hearing Aids	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Home Health Services (Maximum of 120 visits per year)	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Home Infusion Services	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Hospice Services	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Human Growth Hormone, Genetic Testing/Counseling, Other	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	**Member Pays**	**Member Pays**	
	In Network	**In Network**	**In Network**	**Out of Network**
Physical/Occupational Therapy	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Speech Therapy	$40 Copayment per visit	$20 Copayment per visit	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
ALTERNATIVE CARE SERVICES				
There is a combined benefit year benefit maximum of $400.00 paid by the Plan for Alternative Care Services				
Acupuncture	$40 Copayment per visit	$20 co-pay	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Chiropractic Care	$40 Copayment per visit	$20 co-pay	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Naturopathy	$40 Copayment per visit	$20 co-pay	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
Massage Therapy	$40 Copayment per visit	$20 co-pay	0% Coinsurance After Annual Deductible	30% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Charge
VISION PLAN PROVISIONS				
Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery In Lieu Of Glasses	$250 per year, per covered member	$250 per year, per covered member	$250 per year, per covered member	
PHARMACY PROVISIONS (Please refer to Member ID Card for Pharmacy Contact Information	**Member Pays**	**Member Pays**	**Member Pays**	
PHARMACY BENEFITS			**Participating Pharmacies**	**Non-Participating Pharmacies**
Annual Pharmacy Deductible (If applicable will display as Per Person / Per Family)	None	None	None	Not Applicable
Annual Pharmacy Out of Pocket Maximum (If Pharmacy OOP Maximum is Separate from the Medical OOP Maximum will display as Per Person / Per Family)	Combined with the Medical Annual Out of Pocket Maximum	Combined with the Medical Annual Out of Pocket Maximum	$1,700 / $1,700	Not Applicable
Lifetime Maximum				
Preventive Prescription Services				
Mandatory Generic Only - Preventive Prescription Services as defined by PPACA. In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs.				
Prescription Drugs Pharmacy Retail - up to a 31 Day supply	Generic Only - $0	Generic Only - $0	Generic Only - $0	Not Covered
Non-Preventive Prescription Drugs				
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.				
Pharmacy Retail – up to a 31 Day supply (Generic, Preferred, Non-preferred)	Generic - $15 Copayment Preferred Brand - $35 Copayment Non-Preferred Brand - $50 Copayment	Generic - $10 Copayment Preferred Brand - $25 Copayment Non-Preferred Brand - $40 Copayment	Generic - $25 Copayment Preferred Brand - $50 Copayment Non-Preferred Brand - $75 Copayment	Not Covered

Riverstone Capital
Where Healthcare Makes Sense

For Employer Groups (50-1000) Employee Benefits Major Medical plans (PRIVATE EXCHANGE). Affordable pricing options available through collective bargaining among the employer groups participating in the program.

Riverstone Capital, LLC **PPO CIGNA Full Network - Condensed Summary of Plans**	**EPO 40 (CIGNA)**	**EPO 20 (CIGNA)**	**PPO SILVER LEVEL 1 H.S.A (CIGNA)**	
	Member Pays	**Member Pays**	**Member Pays**	
	In Network	**In Network**	**In Network**	**Out of Network**
Prescription Drugs Pharmacy Retail - 90 Day Supply	Generic - $45 Copayment Preferred Brand - $105Copayment Non-Preferred Brand - $150 Copayment	Generic - $30 Copayment Preferred Brand - $75 Copayment Non-Preferred Brand - $120 Copayment	Generic - $75Copayment Preferred Brand - $150Copayment Non-Preferred Brand - $225 Copayment	Not Covered
Prescription Drugs Pharmacy Mail Order - 90 Day Supply	Generic - $30 Copayment Preferred Brand - $70 Copayment Non-Preferred Brand - $100 Copayment	Generic - $20 Copayment Preferred Brand - $50 Copayment Non-Preferred Brand - $80 Copayment	Generic - $50 Copayment Preferred Brand - $100 Copayment Non-Preferred Brand - $150 Copayment	Not Covered
Specialty Drug	Generic - $15 Copayment Preferred Brand - $35 Copayment Non-Preferred Brand - $50 Copayment	Generic - $10 Copayment Preferred Brand - $25 Copayment Non-Preferred Brand - $40 Copayment	Generic - $75Copayment Preferred Brand - $150Copayment Non-Preferred Brand - $225 Copayment	Not Covered

Monthly Cost
Employee Only
Employee + Spouse
Employee + Child(ren)
Family

*Coinsurance amount is based on an approved *Reasonable and Allowed* reimbursement level.

***Precertification* is required for this service.

***After Plan Deductible

Coinsurance amount is based on an approved negotiated rate for Participating Providers or Reasonable & Allowed reimbursement level for Non-Participating Providers as established by the Plan.

This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Plan Document, the latter will take precedence.

In Network: For Participating Providers, the Member is responsible for the difference between the Plan payment and 100% of the negotiated rate for Participating Providers.

Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements

Out of Network: For Non-Participating Providers, the Member is responsible for the amounts listed as well as the difference between the Reasonable and Allowed Charge reimbursement level and 100% of the billed amount. Amounts in excess of the Reasonable and Allowed Charge payable to Non-Participating Providers DO NOT apply to the Annual Deductible NOR the Annual Out-of-Pocket Maximum.