

## BENEFIT SUMMARY



**Cigna Health and Life Insurance Co.**  
**For - Allianz Trade**  
**Choice Fund Open Access Plus HSA Plan**  
**HSA OAP**  
**Effective - 01/01/2023**

**Selection of a Primary Care Provider** - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

**Direct Access to Obstetricians and Gynecologists** - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

**A notice for Missouri residents required by RSMo 376.1199.6:** This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude, and not pay for, coverage for elective abortions if such coverage is contrary to the enrollee's moral, ethical or religious beliefs.

**A notice for Oklahoma residents per 63 Okl. St. § 1-741.3:** This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

**A notice for Texas residents per Tex. Ins. Code §1218.001 et.al.:** This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

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

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Year Accumulation</b>	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a contract year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
<b>Plan Coinsurance</b>	Plan pays 90%	Plan pays 70%
<b>Maximum Reimbursable Charge</b>	Not Applicable	150%

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 Choice Fund Health Savings Account (HSA) Open Access Plus - HSA OAP

Plan Highlights		In-Network	Out-of-Network
<b>Plan Deductible</b>		Individual - Employee Only: \$1,500 Family Maximum: \$3,000	Individual - Employee Only: \$3,000 Family Maximum: \$6,000
<ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.</li> <li>Plan deductible always applies before any benefit copay/deductible or coinsurance.</li> <li>Plan deductible does not apply to in-network preventive services.</li> <li>All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.</li> <li>This plan includes a combined Medical/Pharmacy plan deductible.</li> </ul>			
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).			
<b>Plan Out-of-Pocket Maximum</b>		Individual - Employee Only: \$2,200 Family Maximum: \$4,400	Individual - Employee Only: \$6,600 Family Maximum: \$13,200
<ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</li> <li>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.</li> <li>All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>			
Benefit		In-Network	Out-of-Network
<b>Note:</b> Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		Plan pays 90% ^	Plan pays 70% ^
<b>Specialty Care Physician Services/Office Visit</b>		Plan pays 90% ^	Plan pays 70% ^
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).			
<b>Surgery Performed in Physician's Office</b>		Plan pays 90% ^	Covered same as Physician Services - Office Visit
<b>Allergy Treatment/Injections and Allergy Serum</b> Allergy serum dispensed by the physician in the office		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Virtual Care</b>			
<b>Dedicated Virtual Providers - MDLIVE</b>			
<b>MDLIVE Urgent Virtual Care Services</b>		Plan pays 90% ^	Not Covered

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<ul style="list-style-type: none"> <li>Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).</li> <li>Lab services supporting a virtual visit must be obtained through dedicated labs.</li> <li>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.</li> </ul>		
<b>Virtual Physician Services - Office Visits</b>		
<b>Primary Care Physician (PCP) Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Specialty Care Physician Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</li> <li>Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.</li> </ul>		
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
<b>Preventive Care</b>		
<b>Preventive Care</b> Birth through age 16  Ages 17 and older	Plan pays 100%  Plan pays 100%	PCP: Plan pays 80% Specialist: Plan pays 80%  PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
<ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li> <li>Annual Limit: Unlimited</li> </ul>		
<b>Immunizations</b> Birth through age 16  Ages 17 and older	Plan pays 100%  Plan pays 100%	PCP: Plan pays 80% Specialist: Plan pays 80%  PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
<b>Mammogram, PAP, and PSA Tests</b>	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
<ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.</li> </ul>		
<b>Inpatient</b>		
<b>Inpatient Hospital Facility Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 90% ^	Plan pays 70% ^

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Inpatient Professional Services</b> • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient</b>		
<b>Outpatient Facility Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Professional Services</b> • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 90% ^	Plan pays 70% ^
<b>Emergency Services</b>		
<b>Emergency Room</b> • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 90% ^	Plan pays 90% ^
<b>Urgent Care Facility</b> • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 90% ^	Plan pays 90% ^
<b>Ambulance</b> Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 90% ^	Plan pays 90% ^
<b>Inpatient Services at Other Health Care Facilities</b>		
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> • Annual Limit: 120 days	Plan pays 90% ^	Plan pays 70% ^
<b>Laboratory Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Independent Lab</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Radiology Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Advanced Radiological Imaging (ARI)</b>	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Physician's Services/Office Visit</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Outpatient Therapy Services</b>		

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Outpatient Therapy Services</b>  Annual Limits: <ul style="list-style-type: none"> <li>All Therapies Combined - Includes Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 15 days</li> <li>Habilitative Services and Devices for Dependent children under 19 who need to keep, learn or improve skills and enhance functioning for daily living, until end of the month in which the child turns age 19. Unlimited maximum.</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.</b>		
<b>Chiropractic Services</b>  Annual Limit: <ul style="list-style-type: none"> <li>Chiropractic Care - 12 days</li> </ul>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Note: Includes Bereavement counseling provided as part of a hospice program.</b>		
<b>Bereavement Counseling (for services not provided as part of a hospice program)</b>		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	You pay 10% (not to exceed \$150 per 30-day supply) Plan pays 90% ^	You pay 30% (not to exceed \$150 per 30-day supply) Plan pays 70% ^
<b>Physician's Office</b>	You pay 10% (not to exceed \$150 per 30-day supply) Plan pays 90% ^	You pay 30% (not to exceed \$150 per 30-day supply) Plan pays 70% ^
<b>Home</b>	You pay 10% (not to exceed \$150 per 30-day supply) Plan pays 90% ^	You pay 30% (not to exceed \$150 per 30-day supply) Plan pays 70% ^
<b>Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.</b>		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Maternity</b>		
<b>Initial Visit to Confirm Pregnancy</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges</b> (Global Maternity Fee)	Plan pays 90% ^	Plan pays 70% ^
<b>Office Visits in Addition to Global Maternity Fee</b> (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Delivery - Facility</b> (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
<b>Men's Services</b>	Plan pays 100% ^	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Infertility</b>		
<b>Infertility Treatment</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Outpatient Services: In-vitro fertilization is covered up to 3 attempts per live birth.		
<ul style="list-style-type: none"> <li>Lifetime Maximum: Unlimited</li> </ul>		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Annual Limit: 40 days (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>		
<b>Note:</b> Includes outpatient private duty nursing when approved as medically necessary		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Organ Transplants</b>		
<b>Inpatient Hospital Facility Services</b>		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Plan pays 80% ^
<b>Inpatient Professional Services</b>		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Plan pays 80% ^
<ul style="list-style-type: none"> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, Unlimited maximum per Transplant per Lifetime</li> </ul>		
<b>Durable Medical Equipment</b>		
<ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 90% ^	Plan pays 70% ^
<b>Breast Feeding Equipment and Supplies</b>		
<ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>	Plan pays 100%	Plan pays 80% ^
<b>External Prosthetic Appliances (EPA)</b>		
<ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> <li>External prosthetic appliances meant to replace, in whole or in part, an arm, a leg or an eye: benefit levels will be the same as the benefit levels for primary care benefits.</li> </ul>	Plan pays 90% ^	Plan pays 70% ^
<b>Temporomandibular Joint Disorder (TMJ)</b>		
<ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> </ul>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
<b>Routine Foot Care</b>	Not Covered	Not Covered
<b>Note:</b> Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.		
<b>Hearing Aids</b>		
<ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> <li>Maximum of 2 devices (one per ear) per 36 months</li> <li>Includes testing and fitting of hearing aid devices at Physician Office Visit cost share</li> <li>Coverage through age 18</li> </ul>	Plan pays 90% ^	Plan pays 70% ^
<b>Wigs</b>		
<ul style="list-style-type: none"> <li>One hair prosthesis when prescribed by an oncologist for hair loss suffered as a result of chemotherapy or radiation treatment for cancer.</li> </ul>	Plan pays 90% ^	Plan pays 90% ^
<b>Acupuncture</b>		
<ul style="list-style-type: none"> <li>Annual Limit: 20 days</li> </ul>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Mental Health and Substance Use Disorder</b>		

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<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Inpatient Mental Health</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Mental Health – Physician’s Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Mental Health – All Other Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Inpatient Substance Use Disorder</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Substance Use Disorder – Physician’s Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Substance Use Disorder – All Other Services</b>	Plan pays 90% ^	Plan pays 70% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>Unlimited maximum</li> </ul>		
Notes:		
<ul style="list-style-type: none"> <li>Inpatient includes Acute Inpatient and Residential Treatment.</li> <li>Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.</li> <li>Services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul>		
<b>Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs</b>		
<b>Cigna Total Behavioral Health - Inpatient and Outpatient Management</b>		
<ul style="list-style-type: none"> <li>Inpatient utilization review and case management</li> <li>Outpatient utilization review and case management</li> <li>Partial Hospitalization</li> <li>Intensive outpatient programs</li> <li>Changing Lives by Integrating Mind and Body Program</li> <li>Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.</li> <li>Narcotic Therapy Management</li> <li>inMynd<sup>SM</sup> program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.</li> </ul>		
Pharmacy	In-Network	Out-of-Network
<b>Cost Share and Supply</b>		



Pharmacy	In-Network	Out-of-Network
<p><b>Cigna Pharmacy Cost Share</b></p> <ul style="list-style-type: none"> <li>Retail – up to 90-day supply</li> <li>Home Delivery – up to 90-day supply</li> </ul>	<p><b>Retail (per 30-day supply):</b>            Generic: You pay 10% ^            Preferred Brand: You pay 10% ^            Non-Preferred Brand: You pay 10% ^            Specialty: You pay 10% up to a maximum of \$1 ^</p> <p><b>Retail and Home Delivery (per 90-day supply):</b>            Generic: You pay 10% ^            Preferred Brand: You pay 10% ^            Non-Preferred Brand: You pay 10% ^            Specialty: You pay 10% up to a maximum of \$3 ^</p>	<p><b>Retail:</b>            You pay 20% ^            Your plan pays 80% ^</p> <p><b>Home Delivery:</b>            Same as Retail Out-of-Network</p>

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- You can choose to fill your medications in a 30- or 90-day supply at any network pharmacy.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.

**For Delaware residents:**

For prescription drug plans that include a mail order drug plan (home delivery), the copayment for a 90-day supply at retail or mail order pharmacies will be equal to three times the copayment for a 30-day supply. The copayment for a 90-day supply when obtained from either a retail or mail order drug pharmacy will be equal. The mail order drug plan coinsurance level for a 90-day supply will be the same as the retail coinsurance level. Each prescription order or refill will be limited to up to a consecutive 90-day supply at a mail order or retail participating pharmacy, unless limited by the drug manufacturer's packaging or other applicable law.

**Drugs Covered**

**Prescription Drug List:**

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

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

### Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

## Additional Information

### Case Management

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

### Cigna Diabetes Prevention Program in collaboration with Omada

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (150%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

### Multiple Surgical Reduction

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

### One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

## Additional Information

**Pre-Certification - Continued Stay Review – Complete Care Management Inpatient** - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

**Pre-Certification - Complete Care Management Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

## Definitions

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

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

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

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

**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

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

**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

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

## Exclusions

**What's Not Covered (not all-inclusive):**

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care required by state or federal law to be supplied by a public school system or school district. Behavioral care services provided by a Participating Provider will not be denied solely because it was rendered at a public school or through a school based health center.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or

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## Exclusions

Pharmacy represents that you remain responsible for any amounts that your plan does not cover. This exclusion includes, but is not limited to, charges of a non-Participating Provider, that exceed those agreed upon, if the provider has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - o The subject of an ongoing phase I, II, III or IV clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
  - o In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following:
  - o The national institutes of health (NIH);
  - o An NIH cooperative group or an NIH center;
  - o The FDA in the form of an investigational new drug application;
  - o The federal department of veterans affairs; or
  - o An institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.
- Cosmetic surgery and therapies, except as specified in the "Breast Reconstruction and Breast Prostheses" section of this plan. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an accidental injury to teeth are covered. Additionally, charges made by a Physician for any of the following surgical procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a dentist other than the one who extracted the tooth). Charges for inpatient and outpatient services for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment,

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## Exclusions

involved with the management of the birth defect known as cleft lip or cleft palate, or both, are covered. Charges for diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care Provider rendering the service, the procedure is Medically Necessary to treat a condition caused by congenital deformity, disease or Injury, are covered.

- For medical and surgical services intended for the treatment or control of obesity, except as provided for under "Covered Expenses."
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any claim, bill or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a referral prohibited by the Maryland Health Occupations Article.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan. However, this exclusion does not apply to charges for inpatient hospitalization services and home visits, with respect to a newborn child, as provided in the "Covered Expenses" section.
- Non-medical counseling or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and drive safety courses.
- Consumable medical supplies other than ostomy supplies, urinary catheters, equipment, supplies, complex decongestive therapy, gradient compression garments for the treatment of lymphedema or as otherwise covered items. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms beyond the rates approved by the Health Services Cost Review Commission and/or private duty nursing except as provided under the Home Health Care Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids, specifically: corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as may otherwise be provided for under "Covered Expenses."
- Hearing aids, except as provided for under "Covered Expenses," including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses (except for the first pair of corrective lenses or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.

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## Exclusions

- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements (except for medical foods and modified food products and amino acid-based elemental formula as provided for in the "Covered Expenses" section) and health and beauty aids.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Massage therapy.

### These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file

a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
1.800.368.1019, 800.537.7697 (TDD)  
Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.



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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

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

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけません。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

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