# BENEFIT SUMMARY

**Administered by - Cigna Health and Life Insurance Co.**
**For - ColCal Colorado Inc**
**Open Access Plus Plan**
**OAP Base**
**Effective - 01/01/2024**

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

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Plan Year Accumulation** | Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar 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. | |
| **Plan Coinsurance** | Plan pays 70% | Plan pays 50% |
| **Maximum Reimbursable Charge** | Not Applicable | 110% |
| **Plan Deductible** | Individual: $5,000<br>Family: $15,000 | Individual: $10,000<br>Family: $30,000 |

- 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.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Out-of-Pocket Maximum** | Individual: $6,350<br>Family: $15,000 | Individual: $13,000<br>Family: $39,000 |

- 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.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- 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.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $30 copay, and plan pays 100% | Plan pays 50% ^ |
| **Specialty Care Physician Services/Office Visit** | $45 copay, and plan pays 100% | Plan pays 50% ^ |
| **Surgery Performed in Physician's Office** | Plan pays 70% | Plan pays 50% ^ |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | Plan pays 70% | Not Covered |
| **MDLIVE Primary Care Services** | Plan pays 70% | Not Covered |
| **MDLIVE Specialty Care Services** | Plan pays 70% | Not Covered |

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- 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.

| | | |
|---|---|---|
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | Plan pays 70% | Plan pays 50% ^ |
| **Specialty Care Physician Services/Office Visit** | Plan pays 70% | Plan pays 50% ^ |

- Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).
- 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.

| | | |
|---|---|---|
| **Convenience Care Clinic** | | |
| **Convenience Care Clinic** | $30 copay, and plan pays 100% | Plan pays 50% ^ |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Preventive Care** | | |
| **Preventive Care Office Visit** | Plan pays 100% | Plan pays 50% ^ |
| **Preventive Services**<br>• Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | Plan pays 100% | Plan pays 50% ^ |
| **Immunizations** | Plan pays 100% | Plan pays 50% ^ |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | Plan pays 70% ^ | Plan pays 50% ^ |
| **Emergency Services** | | |
| **Emergency Room**<br>• Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)<br>• Per visit copay is waived if admitted. | $250 copay, and plan pays 80% | |
| **Urgent Care Facility**<br>• Includes Physician Charges, Lab and Radiology | $65 copay, and plan pays 100% | Plan pays 50% ^ |
| **Ambulance** | Plan pays 70% ^ | |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Inpatient Services at Other Health Care Facilities** | | |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities**<br>• Annual Limit: 100 days | Plan pays 70% ^ | Plan pays 50% ^ |
| **Laboratory Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Independent Lab** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Facility** | Plan pays 70% ^ | Plan pays 50% ^ |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Radiology Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Facility** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Physician's Services/Office Visit** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Therapy Services** | | |
| **Outpatient Physical Therapy** | Plan pays 70% ^ | Plan pays 50% ^ |
| Annual Limits:<br>• Physical Therapy – 20 visits<br>• Limits are not applicable to mental health conditions.<br><br>**Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum. | | |
| **Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy** | Plan pays 70% ^ | Plan pays 50% ^ |
| Annual Limits:<br>• Speech, Hearing and Occupational Therapies – 40 visits<br>• Limits are not applicable to mental health conditions for Speech and Occupational Therapies.<br><br>**Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum. | | |
| **Chiropractic Care** | Plan pays 70% ^ | Plan pays 50% ^ |
| Annual Limit:<br>• Chiropractic Care – 20 visits | | |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Services** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Medical Pharmaceutical Drugs** | | |
| **Cigna Pathwell Specialty℠ Medical Pharmaceuticals** | **Cigna Pathwell Specialty℠ Network:**<br>Plan pays 70% ^<br><br>**All other medical network providers:**<br>Not Covered | Not Covered |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Other Medical Pharmaceuticals** | Plan pays 70% ^ | Not Covered |
| **Note:** This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design. | | |
| **Family Planning** | | |
| **Women's Services** | 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) | | |
| **Men's Services** | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| Includes surgical sterilization services, such as vasectomy (excludes reversals) | | |
| **Abortion** | | |
| **Abortion Services** | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Note:** Elective and non-elective procedures | | |
| **Infertility** | | |
| **Infertility Treatment** | 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.<br>• Lifetime Maximum: Unlimited | | |
| **Outpatient Dialysis Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Not Covered |
| **Home Dialysis**<br>**Note:** Dialysis visits will not accumulate to Home Health Care maximum | Covered same as plan's Home Health Care benefit | Not Covered |
| **Outpatient Facility Services** | Covered same as plan's Outpatient Facility Services benefit | Not Covered |
| **Outpatient Professional Services** | Covered same as plan's Outpatient Professional Services benefit | Not Covered |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care** | Plan pays 70% ^ | Plan pays 50% ^ |
| • Annual Limit: 120 visits (The limit is not applicable to mental health and substance use disorder conditions.) | | |
| **Organ Transplants** | Covered same as Inpatient benefit | Not Covered |
| • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.<br>• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant | | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Condition-Specific Care** | Plan pays 100% | Not Applicable |
| • Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify.<br>• Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply.<br>• Travel Maximum - $600 per procedure | | |
| **Durable Medical Equipment and External Prosthetic Appliances**<br>• Annual Limit: Unlimited | Plan pays 70% ^ | Plan pays 50% ^ |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician<br>• Includes related supplies | Plan pays 100% | Plan pays 50% ^ |
| **Acupuncture**<br>• Annual Limit: 12 visits | Plan pays 70% ^ | Not Covered |
| **Note: Services where plan deductible applies are noted with a caret (^).** | | |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Mental Health – Physician's Office** | $45 copay, and plan pays 100% | Plan pays 50% ^ |
| **Outpatient Mental Health - MDLIVE Behavioral Services** | $45 copay, and plan pays 100% | Not Covered |
| **Outpatient Mental Health – All Other Services** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Inpatient Substance Use Disorder** | Plan pays 70% ^ | Plan pays 50% ^ |
| **Outpatient Substance Use Disorder – Physician's Office** | $45 copay, and plan pays 100% | Plan pays 50% ^ |
| **Outpatient Substance Use Disorder - MDLIVE Behavioral Services** | $45 copay, and plan pays 100% | Not Covered |
| **Outpatient Substance Use Disorder – All Other Services** | Plan pays 70% ^ | Plan pays 50% ^ |
| Annual Limits:<br>• Unlimited maximum<br><u>Notes:</u><br>• Inpatient includes Acute Inpatient and Residential Treatment.<br>• Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.<br>• Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.<br><br>**Important Note on Mental Health and Substance Use Disorder Coverage:** Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder." | | |
| **Pharmacy** | **In-Network** | **Out-of-Network** |
| **Cost Share and Supply** | | |

| Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| **Pharmacy Cost Share**<br>• Retail – up to 90-day supply (except Specialty up to 30-day supply)<br>• Home Delivery – up to 90-day supply<br>• If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share. | **Retail (per 30-day supply):**<br>Generic: You pay $15<br>Preferred Brand: You pay $30<br>Non-Preferred Brand: You pay $250<br><br>**Retail (per 90-day supply):**<br>Generic: You pay $38<br>Preferred Brand: You pay $75<br>Non-Preferred Brand: You pay $625<br><br>**Home Delivery (per 90-day supply):**<br>Generic: You pay $45<br>Preferred Brand: You pay $90<br>Non-Preferred Brand: You pay $750 | **Retail:**<br>You pay 50%<br>Your plan pays 50%<br><br>**Home Delivery:**<br>Not Covered |
| • Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.<br>• Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.<br>• 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.<br>• When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).<br>• Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.<br>• **SaveOn Specialty Program:** If you participate in the SaveOnSP program, certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. In that case, manufacturer assistance may not be applied towards your deductible and out-of-pocket maximums.<br>• Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits. | | |
| **Preventive Drugs:**<br>Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network Generic preventive drugs and products included in the Preventive Plus Package will be provided at no charge. This may apply to drugs for:<br>Asthma, Cholesterol Lowering, Depression, Diabetes (including diabetic supplies and continuous glucose monitor supplies), Heart Disease and Stroke, High Blood Pressure, Osteoporosis, Prenatal Vitamins, Prescription Vitamins | | |
| **Pharmacy Out-of-Pocket Maximum**<br>• Retail and Home Delivery cost share applies to the Pharmacy Out-of-Pocket. | Individual: Combined With Medical<br>Family: Combined With Medical | |

## Drugs Covered

**Prescription Drug List:**
Your Cigna Advantage Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- 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.

**Clinical Day Supply Program**
Your plan includes the Clinical Day Supply Program for specialty drugs which provides a balance between specialty drug waste control and improved therapy adherence. During a stabilization period, certain specialty drugs, dispensed by a Cigna designated specialty pharmacy, may be limited to less than a consecutive 90 day supply. Further, for some drugs with a very high risk for early discontinuation, a split-fill (either 14 or 15 days), may be dispensed. Your cost share will be prorated to reflect the actual days' supply dispensed.

**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

**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 (110%) 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 Calendar 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.**

**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.

| | |
|---|---|
| **Out-of-Area Services**<br>• Coverage for services rendered outside a network area<br>• ER and Ambulance paid the same as network services<br>• Preventive care services covered at 100% for Out-of-Area<br>• Out-of-Network Deductible and Out-of-Pocket maximums apply | For all other services, plan pays 60%<br>after the out-of-network deductible is met |

**Complete Care Management**
Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $750 penalty will be applied.

## Additional Information

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

**Well-Being Solution: Core Plus**

- Health Assessment
- Device/App Integration
- Personalized online content and date-driven actions
- Social connections/challenges

## 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 (This Is Not All Inclusive; check your plan documents for a complete list)**

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Non-emergency services incurred outside the United States
- Bariatric surgery - except when medical necessity guidelines are met
- Treatment of TMJ disorders and craniofacial muscle disorders

**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.

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation.*

EHB State: CO

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.




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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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# BENEFIT SUMMARY

**Administered by - Cigna Health and Life Insurance Co.**
**For - ColCal Colorado Inc**
**Open Access Plus Plan**
**OAP Buy Up**
**Effective - 01/01/2024**

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

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Plan Year Accumulation** | Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar 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. | |
| **Plan Coinsurance** | Plan pays 80% | Plan pays 60% |
| **Maximum Reimbursable Charge** | Not Applicable | 110% |
| **Plan Deductible** | Individual: $1,000<br>Family: $3,000 | Individual: $2,500<br>Family: $8,400 |

- 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.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Out-of-Pocket Maximum** | Individual: $3,300<br>Family: $8,400 | Individual: $4,000<br>Family: $10,300 |

- 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.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- 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.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $30 copay, and plan pays 100% | Plan pays 60% ^ |
| **Specialty Care Physician Services/Office Visit** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| **Surgery Performed in Physician's Office** | Plan pays 80% | Plan pays 60% ^ |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | $0 copay, and plan pays 100% | Not Covered |
| **MDLIVE Primary Care Services** | $0 copay, and plan pays 100% | Not Covered |
| **MDLIVE Specialty Care Services** | $0 copay, and plan pays 100% | Not Covered |

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- 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.

| | | |
|---|---|---|
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $0 copay, and plan pays 100% | Plan pays 60% ^ |
| **Specialty Care Physician Services/Office Visit** | $0 copay, and plan pays 100% | Plan pays 60% ^ |

- Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).
- 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.

| | | |
|---|---|---|
| **Convenience Care Clinic** | | |
| **Convenience Care Clinic** | $30 copay, and plan pays 100% | Plan pays 60% ^ |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Preventive Care** | | |
| **Preventive Care Office Visit** | Plan pays 100% | Plan pays 60% ^ |
| **Preventive Services** | Plan pays 100% | Plan pays 60% ^ |
| • Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | | |
| **Immunizations** | Plan pays 100% | Plan pays 60% ^ |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Inpatient Professional Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Professional Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Emergency Services** | | |
| **Emergency Room**<br>• Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)<br>• Per visit copay is waived if admitted. | $250 copay, and plan pays 80% | |
| **Urgent Care Facility**<br>• Includes Physician Charges, Lab and Radiology | $65 copay, and plan pays 80% ^ | Plan pays 60% ^ |
| **Ambulance** | Plan pays 80% ^ | |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Inpatient Services at Other Health Care Facilities** | | |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities**<br>• Annual Limit: 100 days | Plan pays 80% ^ | Plan pays 60% ^ |
| **Laboratory Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Independent Lab** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Radiology Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Physician's Services/Office Visit** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Therapy Services** | | |
| **Outpatient Physical Therapy** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| Annual Limits:<br>• Physical Therapy – 20 visits<br>• Limits are not applicable to mental health conditions.<br><br>**Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum. | | |
| **Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| Annual Limits:<br>• Speech, Hearing and Occupational Therapies – 40 visits<br>• Limits are not applicable to mental health conditions for Speech and Occupational Therapies.<br><br>**Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum. | | |
| **Chiropractic Care** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| Annual Limit:<br>• Chiropractic Care – 20 visits | | |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Medical Pharmaceutical Drugs** | | |
| **Cigna Pathwell Specialty℠ Medical Pharmaceuticals** | **Cigna Pathwell Specialty℠ Network:**<br>Plan pays 80% ^<br><br>**All other medical network providers:**<br>Not Covered | Not Covered |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Other Medical Pharmaceuticals** | Plan pays 80% ^ | Not Covered |
| **Note:** This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design. | | |
| **Family Planning** | | |
| **Women's Services** | 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) | | |
| **Men's Services** | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| Includes surgical sterilization services, such as vasectomy (excludes reversals) | | |
| **Abortion** | | |
| **Abortion Services** | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Note:** Elective and non-elective procedures | | |
| **Infertility** | | |
| **Infertility Treatment** | 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.<br>• Lifetime Maximum: Unlimited | | |
| **Outpatient Dialysis Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Not Covered |
| **Home Dialysis**<br>**Note:** Dialysis visits will not accumulate to Home Health Care maximum | Covered same as plan's Home Health Care benefit | Not Covered |
| **Outpatient Facility Services** | Covered same as plan's Outpatient Facility Services benefit | Not Covered |
| **Outpatient Professional Services** | Covered same as plan's Outpatient Professional Services benefit | Not Covered |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care** | Plan pays 80% ^ | Plan pays 60% ^ |
| • Annual Limit: 120 visits (The limit is not applicable to mental health and substance use disorder conditions.) | | |
| **Organ Transplants** | Covered same as Inpatient benefit | Not Covered |
| • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.<br>• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant | | |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.** | | |
| **Condition-Specific Care** | Plan pays 100% | Not Applicable |
| • Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify.<br>• Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply.<br>• Travel Maximum - $600 per procedure | | |
| **Durable Medical Equipment and External Prosthetic Appliances**<br>• Annual Limit: Unlimited | Plan pays 80% ^ | Plan pays 60% ^ |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician<br>• Includes related supplies | Plan pays 100% | Plan pays 60% ^ |
| **Acupuncture**<br>• Annual Limit: 12 visits | $45 copay, and plan pays 100% | Not Covered |
| **Note: Services where plan deductible applies are noted with a caret (^).** | | |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Mental Health – Physician's Office** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| **Outpatient Mental Health - MDLIVE Behavioral Services** | $45 copay, and plan pays 100% | Not Covered |
| **Outpatient Mental Health – All Other Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Inpatient Substance Use Disorder** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Substance Use Disorder – Physician's Office** | $45 copay, and plan pays 100% | Plan pays 60% ^ |
| **Outpatient Substance Use Disorder - MDLIVE Behavioral Services** | $45 copay, and plan pays 100% | Not Covered |
| **Outpatient Substance Use Disorder – All Other Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| Annual Limits:<br>• Unlimited maximum<br>Notes:<br>• Inpatient includes Acute Inpatient and Residential Treatment.<br>• Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.<br>• Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.<br><br>**Important Note on Mental Health and Substance Use Disorder Coverage:** Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder." | | |
| **Pharmacy** | **In-Network** | **Out-of-Network** |
| **Cost Share and Supply** | | |

| Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| **Pharmacy Cost Share**<br>• Retail – up to 90-day supply (except Specialty up to 30-day supply)<br>• Home Delivery – up to 90-day supply<br>• If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share. | **Retail (per 30-day supply):**<br>Generic: You pay $15<br>Preferred Brand: You pay $30<br>Non-Preferred Brand: You pay $250<br><br>**Retail (per 90-day supply):**<br>Generic: You pay $38<br>Preferred Brand: You pay $75<br>Non-Preferred Brand: You pay $625<br><br>**Home Delivery (per 90-day supply):**<br>Generic: You pay $45<br>Preferred Brand: You pay $90<br>Non-Preferred Brand: You pay $750 | **Retail:**<br>You pay 50%<br>Your plan pays 50%<br><br>**Home Delivery:**<br>Not Covered |

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- **SaveOn Specialty Program:** If you participate in the SaveOnSP program, certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. In that case, manufacturer assistance may not be applied towards your deductible and out-of-pocket maximums.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

**Preventive Drugs:**
Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network Generic preventive drugs and products included in the Preventive Plus Package will be provided at no charge. This may apply to drugs for:

Asthma, Cholesterol Lowering, Depression, Diabetes (including diabetic supplies and continuous glucose monitor supplies), Heart Disease and Stroke, High Blood Pressure, Osteoporosis, Prenatal Vitamins, Prescription Vitamins

## Drugs Covered

**Prescription Drug List:**
Your Cigna Advantage Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- 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.

**Clinical Day Supply Program**
Your plan includes the Clinical Day Supply Program for specialty drugs which provides a balance between specialty drug waste control and improved therapy adherence. During a stabilization period, certain specialty drugs, dispensed by a Cigna designated specialty pharmacy, may be limited to less than a consecutive 90 day supply. Further, for some drugs with a very high risk for early discontinuation, a split-fill (either 14 or 15 days), may be dispensed. Your cost share will be prorated to reflect the actual days' supply dispensed.

**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

**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 (110%) 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 Calendar 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.**

**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.

| | |
|---|---|
| **Out-of-Area Services**<br>• Coverage for services rendered outside a network area<br>• ER and Ambulance paid the same as network services<br>• Preventive care services covered at 100% for Out-of-Area<br>• Out-of-Network Deductible and Out-of-Pocket maximums apply | For all other services, plan pays 80%<br>after the out-of-network deductible is met |

**Complete Care Management**
Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $750 penalty will be applied.

## Additional Information

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

**Well-Being Solution: Core Plus**

- Health Assessment
- Device/App Integration
- Personalized online content and date-driven actions
- Social connections/challenges

## 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 (This Is Not All Inclusive; check your plan documents for a complete list)**

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Non-emergency services incurred outside the United States
- Bariatric surgery - except when medical necessity guidelines are met
- Treatment of TMJ disorders and craniofacial muscle disorders

**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.

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation.*

EHB State: CO

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.




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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: $5,000/individual or $15,000/family<br>For out-of-network providers: $10,000/individual or $30,000/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care, office visits, prescription drugs, emergency room visits, in-network urgent care facility visits. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in-network providers: $6,350/individual or $15,000/family<br>For out-of-network providers: $13,000/individual or $39,000/family<br>Combined medical/behavioral and pharmacy out-of-pocket limit | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.cigna.com or call 1-866-494-2111 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/office visit**<br>30% coinsurance/virtual visit**<br>**Deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $45 copay/office visit**<br>30% coinsurance/virtual visit**<br>**Deductible does not apply | 50% coinsurance | None |
| | Preventive care/ screening/immunization | No charge<br>Deductible does not apply | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance at an outpatient facility<br>30% coinsurance in the office | 50% coinsurance at an outpatient facility<br>50% coinsurance in the office | $750 penalty for no out-of-network precertification. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.cigna.com | Generic drugs (Tier 1) | $15 copay/prescription (retail 30 days), $38 copay/prescription (retail 90 days); $45 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs.<br>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.<br>For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
| | Preferred brand drugs (Tier 2) | $30 copay/prescription (retail 30 days), $75 copay/prescription (retail 90 days); $90 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | |
| | Non-preferred brand drugs (Tier 3) | $250 copay/prescription (retail 30 days), $625 copay/prescription (retail 90 days); $750 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit, plus 20% coinsurance<br>Deductible does not apply | $250 copay/visit, plus 20% coinsurance<br>Deductible does not apply | Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Out-of-network air ambulance services are paid at the in-network cost share and deductible. |
| | Urgent care | $65 copay/visit<br>Deductible does not apply | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45 copay/office visit**<br>30% coinsurance/all other services<br>**Deductible does not apply | 50% coinsurance/office visit<br>50% coinsurance/all other services | $750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses. |
| | Inpatient services | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses. |
| **If you are pregnant** | Office visits | 30% coinsurance | 50% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. Coverage is limited to 120 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.) |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | 30% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy<br><br>30% coinsurance/visit for Chiropractic care | 50% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy<br><br>50% coinsurance/visit for Chiropractic care | $750 penalty for failure to precertify out-of-network speech therapy.<br>Coverage is limited to an annual max of 20 visits for Physical therapy and 40 visits for Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | 30% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy | 50% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy | $750 penalty for failure to precertify out-of-network speech therapy.<br>Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification.<br>Coverage is limited to 100 days annual max. |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | $750 penalty for no out-of-network precertification. |
| | Hospice services | 30% coinsurance/inpatient services<br>30% coinsurance/outpatient services | 50% coinsurance/inpatient services<br>50% coinsurance/outpatient services | $750 penalty for no out-of-network precertification. |
| **If your child needs dental** | Children's eye exam | Not covered | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **or eye care** | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (in-network only 12 visits)
- Bariatric surgery
- Chiropractic care (20 visits)
- Infertility treatment

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

### Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $30 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | $6,350 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $120 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | $960 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,340 |
| Copayments | $300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,740 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**Plan Name:** OAP Base **Ben Ver:** 28 **Plan ID:** 28160893

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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 or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.




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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: $1,000/individual or $3,000/family<br>For out-of-network providers: $2,500/individual or $8,400/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care, office visits, prescription drugs, emergency room visits. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For in-network providers: $3,300/individual or $8,400/family<br>For out-of-network providers: $4,000/individual or $10,300/family<br>Combined medical/behavioral and pharmacy out-of-pocket limit | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.cigna.com or call 1-866-494-2111 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/office visit**<br>No charge/virtual visit**<br>**Deductible does not apply | 40% coinsurance | None |
| | Specialist visit | $45 copay/office visit**<br>No charge/virtual visit**<br>**Deductible does not apply | 40% coinsurance | None |
| | Preventive care/ screening/immunization | No charge<br>Deductible does not apply | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance at an outpatient facility<br>20% coinsurance in the office | 40% coinsurance at an outpatient facility<br>40% coinsurance in the office | $750 penalty for no out-of-network precertification. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.cigna.com | Generic drugs (Tier 1) | $15 copay/prescription (retail 30 days), $38 copay/prescription (retail 90 days); $45 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs.<br>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.<br>For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
| | Preferred brand drugs (Tier 2) | $30 copay/prescription (retail 30 days), $75 copay/prescription (retail 90 days); $90 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | |
| | Non-preferred brand drugs (Tier 3) | $250 copay/prescription (retail 30 days), $625 copay/prescription (retail 90 days); $750 copay/prescription (home delivery 90 days)<br>Deductible does not apply | 50% coinsurance/prescription (retail); Not covered (home delivery)<br>Deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit, plus 20% coinsurance<br>Deductible does not apply | $250 copay/visit, plus 20% coinsurance<br>Deductible does not apply | Per visit copay is waived if admitted.<br>Out-of-network services are paid at the in-network cost share. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network air ambulance services are paid at the in-network cost share and deductible. |
| | Urgent care | $65 copay/visit, plus 20% coinsurance | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45 copay/office visit**<br>20% coinsurance/all other services<br>**Deductible does not apply | 40% coinsurance/office visit<br>40% coinsurance/all other services | $750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses. |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. Coverage is limited to 120 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.) |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | $45 copay/visit for Physical, Speech, Hearing & Occupational therapy**<br><br>$45 copay/visit for Chiropractic care**<br>**Deductible does not apply | 40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy<br><br>40% coinsurance/visit for Chiropractic care | $750 penalty for failure to precertify out-of-network speech therapy.<br>Coverage is limited to an annual max of 20 visits for Physical therapy and 40 visits for Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | $45 copay/visit for Physical, Speech, Hearing & Occupational therapy**<br>**Deductible does not apply | 40% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy | $750 penalty for failure to precertify out-of-network speech therapy.<br>Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification.<br>Coverage is limited to 100 days annual max. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | $750 penalty for no out-of-network precertification. |
| | Hospice services | 20% coinsurance/inpatient services<br>20% coinsurance/outpatient services | 40% coinsurance/inpatient services<br>40% coinsurance/outpatient services | $750 penalty for no out-of-network precertification. |
| **If your child needs dental** | Children's eye exam | Not covered | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **or eye care** | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (in-network only 12 visits)
- Bariatric surgery
- Chiropractic care (20 visits)
- Infertility treatment

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

### Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $30 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | $3,320 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $120 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | $960 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $980 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,580 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**Plan Name:** OAP Buy Up **Ben Ver:** 28 **Plan ID:** 28160873

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# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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Cigna:

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

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

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.




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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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