# BENEFIT SUMMARY

**Cigna Health and Life Insurance Co.**
**For - Center For Family Services**
**PPO Plan**
**PPO Base Plan**
**Effective - 07/01/2026**

**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.

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

| 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 60% | Plan pays 50% |
| **Maximum Reimbursable Charge** | Not Applicable | 200% |
| **Plan Deductible** | Individual: $2,500<br>Family: $5,000 | Individual: $7,500<br>Family: $15,000 |

- 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 (^).


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| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Out-of-Pocket Maximum** | Individual: $6,600<br>Family: $13,200 | Individual: $20,000<br>Family: $40,000 |

- 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** | $40 copay, and plan pays 100% | Plan pays 50% ^ |
| **Specialty Care Physician Services/Office Visit** | $60 copay, and plan pays 100% | Plan pays 50% ^ |
| **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Surgery Performed in Physician's Office** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Allergy Treatment/Injections and Allergy Serum**<br>Allergy serum dispensed by the physician in the office<br><br>**Note:** Office copay does not apply if only the allergy serum is provided. | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | $40 copay, and plan pays 100% | Not Covered |
| **MDLIVE Primary Care Services** | $40 copay, and plan pays 100% | Not Covered |
| **MDLIVE Specialty Care Services** | $60 copay, and plan pays 100% | Not Covered |

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- 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.


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| 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.** | | |
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | $40 copay, and plan pays 100% | Plan pays 50% ^ |
| **Specialty Care Physician Services/Office Visit** | $60 copay, and plan pays 100% | Plan pays 50% ^ |
| • Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).<br>• 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.<br>**NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Convenience Care Clinic** | | |
| **Convenience Care Clinic** | $40 copay, and plan pays 100% | Plan pays 50% ^ |
| **Preventive Care** | | |
| **Preventive Care** | Plan pays 100% | PCP: Plan pays 50% ^<br>Specialist: Plan pays 50% ^ |
| • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.<br>• Annual Limit: Unlimited | | |
| **Immunizations** | Plan pays 100% | PCP: Plan pays 50% ^<br>Specialist: Plan pays 50% ^ |
| **Mammogram, PAP, and PSA Tests** | Plan pays 100% | Covered same as other x-ray and lab services, based on Place of Service |
| • Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service. | | |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Inpatient Professional Services** | Plan pays 60% ^ | Plan pays 50% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Outpatient Professional Services** | Plan pays 60% ^ | Plan pays 50% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |


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| 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.** | | |
| **Emergency Services** | | |
| **Emergency Room**<br>• Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.<br>• Per visit copay is waived if admitted.<br>• An additional per scan copay of $100 applies to Advanced Radiological Imaging. | $100 copay, and plan pays 100% | $100 copay, and plan pays 100% |
| **Urgent Care Facility**<br>• Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.<br>• An additional per scan copay of $100 applies to Advanced Radiological Imaging. | $50 copay, and plan pays 100% | $50 copay, and plan pays 100% |
| **Ambulance** | Plan pays 60% ^ | Plan pays 60% ^ |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Ambulance - Mental Health and Substance Use Disorder** | Plan pays 100% | Plan pays 100% |
| • 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: 120 days | Plan pays 60% ^ | 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 100% | Plan pays 50% ^ |
| **Outpatient Facility** | Plan pays 100% | Plan pays 50% ^ |
| **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 100% | Plan pays 50% ^ |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | $100 copay per type of scan per day, and plan pays 100%(plan deductible does not apply) | Plan pays 50% ^ |
| **Physician's Services/Office Visit** | $100 copay per type of scan per day, and plan pays 100%(plan deductible does not apply) | Covered same as Physician Services - Office Visit |


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| 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.** | | |
| **Outpatient Therapy Services** | | |
| **Outpatient Therapy Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limits:<br>• Speech therapy - 20 days<br>• Occupational therapy and physical therapy - 30 days<br>• All other therapies - Includes cognitive therapy and pulmonary rehabilitation - 20 days<br>• Limits are not applicable to mental health conditions for physical, speech and occupational therapies.<br><br>**Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum. | | |
| **Chiropractic Services** | $25 copay, and plan pays 100% | Covered same as Physician Services - Office Visit |
| Annual Limit:<br>• Chiropractic Care - 20 days | | |
| **Cardiac Rehabilitation Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit:<br>• Cardiac rehabilitation - 36 days | | |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Outpatient Services** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Bereavement Counseling (for services not provided as part of a hospice program)** | | |
| Services Provided by a Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Medical Pharmaceutical Drugs** | | |
| **Cigna Pathwell Specialty® Medical Pharmaceuticals** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Other Medical Pharmaceuticals** | Plan pays 60% ^ | Plan pays 50% ^ |
| • Cigna Pathwell Specialty® Medical Pharmaceuticals are only covered when administered by a Cigna Pathwell Specialty® designated provider.<br>• 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. | | |


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| 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.** | | |
| **Maternity** | | |
| **Initial Visit to Confirm Pregnancy** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges** (Global Maternity Fee) | Plan pays 60% ^ | Plan pays 50% ^ |
| **Office Visits in Addition to Global Maternity Fee** (Performed by OB/GYN or Specialist) | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Delivery - Facility** (Inpatient Hospital, Birthing Center) | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |
| **Abortion** | | |
| **Abortion Services**<br>**Note:** Elective and non-elective procedures | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Family Planning** | | |
| **Women's Services**<br>Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals) | Plan pays 100% | Coverage varies based on Place of Service |
| **Men's Services**<br>Includes surgical sterilization services, such as vasectomy (excludes reversals) | Plan pays 100% | Coverage varies based on Place of Service |
| **Infertility** | | |
| **Infertility Treatment**<br>Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.<br>• Lifetime Maximum: Unlimited | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Outpatient Dialysis Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Home Dialysis** | Covered same as plan's Home Health Care benefit | Covered same as plan's Home Health Care benefit |
| **Outpatient Facility Services** | Covered same as plan's Outpatient Facility Services benefit | Covered same as plan's Outpatient Facility Services benefit |
| **Outpatient Professional Services** | Covered same as plan's Outpatient Professional Services benefit | Covered same as plan's Outpatient Professional Services benefit |


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| 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 Health Care Facilities/Services** | | |
| **Home Health Care**<br>• Annual Limit: Unlimited | Plan pays 60% ^ | Plan pays 50% ^ |
| **Note:** Includes outpatient private duty nursing when approved as medically necessary | | |
| **Organ Transplants** | | |
| **Inpatient Hospital Facility Services** | | |
| LifeSOURCE Transplant Network® facility | Plan pays 100% | Not Applicable |
| Other Facility | Plan pays 60% ^ | Plan pays 50% ^ |
| **Inpatient Professional Services** | | |
| LifeSOURCE Transplant Network® facility | Plan pays 100% | Not Applicable |
| Other Facility | Plan pays 60% ^ | Plan pays 50% ^ |
| • Travel Maximum - $10,000 maximum per Transplant per Lifetime | | |
| **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**<br>• Annual Limit: Unlimited | Plan pays 100% | Plan pays 50% ^ |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of two breast pumps per birth as ordered or prescribed by a physician<br>• Includes related supplies | Plan pays 100% | Plan pays 100% |
| **External Prosthetic Appliances (EPA)** | Plan pays 100% | Plan pays 50% ^ |
| • Annual Limit: Unlimited | | |
| **Routine Foot Care** | Not Covered | Not Covered |
| **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary. | | |
| **Hearing Aids** | Plan pays 100% | Plan pays 100% |
| • Annual Limit: Unlimited<br>• Maximum of 2 devices (one per ear) per 24 months<br>• Includes testing and fitting of hearing aid devices at Physician Office Visit cost share | | |
| **Acupuncture**<br>• Annual Limit: 12 days | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |


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| 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.** | | |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Outpatient Mental Health - Physician's Office** | $60 copay, and plan pays 100% | Plan pays 50% ^ |
| **Outpatient Mental Health - All Other Services** | Plan pays 100% | Plan pays 50% ^ |
| **Inpatient Substance Use Disorder** | Plan pays 60% ^ | Plan pays 50% ^ |
| **Outpatient Substance Use Disorder - Physician's Office** | $60 copay, and plan pays 100% | Plan pays 50% ^ |
| **Outpatient Substance Use Disorder - All Other Services** | Plan pays 100% | Plan pays 50% ^ |

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All other services - may include partial hospitalization, intensive outpatient services, Applied Behavior Analysis (ABA therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

**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."

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

**Cigna Total Behavioral Health - Inpatient and Outpatient Management**

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.


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| Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| **Cost Share and Supply** | | |
| **Cigna Pharmacy Cost Share**<br>• Retail – up to 90-day supply<br>• Home Delivery – up to 90-day supply | **Retail (per 30-day supply):**<br>Generic: You pay $10<br>Preferred Brand: You pay 30% up to a maximum of $50<br>Non-Preferred Brand: You pay 50% up to a maximum of $75<br><br>**Retail and Home Delivery (per 90-day supply):**<br>Generic: You pay $20<br>Preferred Brand: You pay 30% up to a maximum of $100<br>Non-Preferred Brand: You pay 50% up to a maximum of $150 | **Retail:**<br>You pay 50%<br>Your plan pays 50%<br><br>**Home Delivery:**<br>Same as Retail Out-of-Network |

- **Member Choice Cigna 90 Now:** This network of pharmacies includes major retail chains of Walgreens and CVS, in addition to other grocery, retailer, and independent pharmacies. You will be aligned to either the Walgreens or CVS network based on your existing pharmacy relationship. Where no relationship exists, you will be aligned to plan sponsor elected CVS pharmacy. If that designation is not right for you, there is the option to select Walgreens. For more information, go to myCigna.com or call the number on the back of your ID card. 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.
- Patient is responsible for the applicable cost share based upon the tier of the dispensed medication.
- Pharmacist will dispense the brand medication, and the patient will pay the generic cost share, when the medication is part of the Brand-for-Generic Substitution Program (DAW9).
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- When using a glucagon-like peptide 1 (GLP-1), it is important to have extra clinical care and support from your doctor and pharmacist. There are pharmacies in your plan's network that can help including Evernorth EnGuide℠ Pharmacy.

**For Delaware residents:**

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


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## Drugs Covered

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

- Coverage includes self administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Lifestyle drugs are covered - limited to sexual dysfunction.
- Oral fertility drugs are covered.
- Prescription smoking cessation 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
- 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
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

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

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

## Additional Information

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


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## 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.

| | |
|---|---|
| **Comprehensive Oncology Program**<br>• Care Management outreach<br>• Case Management | Included |
| **Healthy Pregnancies/Healthy Babies**<br>• Care Management outreach<br>• Maternity Case Management<br>• Neo-natal Case Management | $150 (1st trimester) / $75 (2nd trimester) - Option 3 |

**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 (200%) 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.


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## Additional Information

**Medicare Coordination**
In accordance with the Social Security Act of 1965, this plan will pay Secondary 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 Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

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

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

**Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient** - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

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

**Pre-Certification - Preferred Care Management Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

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

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

**Well-Being Solution: Core Plus**

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges


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## Additional Information

**Your Health First - 300**
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

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

Holistic health support for the following chronic health conditions:

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

## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.
**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.


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## Exclusions

- Treatment of a military, non-combatant civilian, or civilian illness or Injury which is due to war, declared or undeclared. Military exclusions exclude treatment of an illness or Injury suffered: as a result of war or an act of war, if the illness or Injury occurs while the insured person is serving in the military, naval or air forces of any country, combination of countries or international organization; and as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or Injury occurs while the insured person is serving in such unit and is outside the 50 United States of America, Puerto Rico, U.S. Virgin Islands, the District of Columbia or Canada.
- Charges which you are not obligated to pay or for which you are not billed. This exclusion includes, but is not limited to:
    - o any instance where Cigna determines that a provider or Pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Service (as shown on the Schedule) without Cigna's express consent.
    - o charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

      In the event that Cigna determines that this exclusion applies, then Cigna shall have the right to:
        - require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
        - deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
        - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- Charges or payment for healthcare-related services that violate state or federal law.
- For or in connection with experimental, investigational or unproven services, except for bone marrow transplants as treatment for Wilms' tumor and except for drugs not recognized for the treatment of the particular indication in standard reference compendia or in medical literature.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
    - o The subject of an ongoing phase I, II or III clinical trial, except routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized for the treatment of cancer in any one of the following: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; U.S. Pharmacopeia Drug Information; or a U.S. peer-reviewed national professional journal.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. This exclusion does not apply to the necessary care and treatment of a Dependent child from the moment of birth with a medically diagnosed congenital defect or birth abnormality.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose


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## Exclusions

veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- Surgical or non-surgical treatment of TMJ disorders and craniofacial muscle disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an Injury to teeth are covered.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction.
- Medical and Hospital care and costs for the child of a Dependent child beyond 60 days after the child's birth, unless the child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- Tuition for schools, facilities or programs that render intensive behavioral interventions.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Diabetic Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. This exclusion does not apply to coverage for hearing aids for Dependent children 15 years of age or younger.
- Eyeglass lenses and frames, and associated services (exams and fittings) except the initial set after treatment of keratoconus or following cataract surgery.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.


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## Exclusions

- Membership costs and fees associated with health clubs and weight loss programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Health and beauty aids, cosmetics and dietary supplements.
- All nutritional supplements, formulae, enteral feedings, supplies and specialty formulated medical foods, whether prescribed or not, except as provided for in “Covered Expenses.”
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Massage therapy.
- Any services, supplies or equipment intended primarily to provide a safe environment, including, but not limited to: helmets, safety goggles/glasses, bed exit monitors, restraints, telephone alert systems, fire extinguishers, smoke/carbon monoxide detectors, fall detection systems, safety rails, fixtures to real property to create a safe surrounding, first aid kits, automatic external defibrillators.

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

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EHB State: NJ


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# Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

**Cigna Healthcare:**

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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
**https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

cigna healthcare

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## Proficiency of Language Assistance Services

**English –** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish –** ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese –** 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

**Vietnamese –** XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean –** 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

**Tagalog –** PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian –** ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic -** تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711 :TTY) 1-800-244-6224

**French Creole –** ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French –** ATTENTION : Si vows parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese –** ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish –** UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese –** 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

**Italian –** ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

**German –** Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) -** همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره1-800-244-6224.ارائه‌دهنده خود صحبت کنید

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