

## BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.  
For - Rady Children's Health  
Open Access Plus  
HDHPQ Low  
Effective - 01/01/2026



**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](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

| Plan Highlights                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | In-Network                                                                                                                                                                                                                                                                                 | Out-of-Network                                                                                             |
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| <b>Lifetime Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Unlimited                                                                                                                                                                                                                                                                                  | Unlimited                                                                                                  |
| <b>Plan Year Accumulation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a 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. |                                                                                                            |
| <b>Plan Coinsurance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Plan pays 70%                                                                                                                                                                                                                                                                              | Plan pays 50%                                                                                              |
| <b>Maximum Reimbursable Charge</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Not Applicable                                                                                                                                                                                                                                                                             | 110%                                                                                                       |
| <b>Plan Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Individual - Employee Only: \$6,000<br>Individual - within a Family: \$6,000<br>Family Maximum: \$12,000                                                                                                                                                                                   | Individual - Employee Only: \$10,000<br>Individual - within a Family: \$10,000<br>Family Maximum: \$20,000 |
| <ul style="list-style-type: none"><li>Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.</li><li>Plan deductible always applies before any benefit copay/deductible or coinsurance.</li><li>Plan deductible does not apply to in-network preventive services.</li><li>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.</li><li>This plan includes a combined Medical/Pharmacy plan deductible.</li><li>In-Network Generic and Preferred Brand preventive drugs and products included in the Preventive Plus Package will not be subject to deductible. 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.</li></ul> |                                                                                                                                                                                                                                                                                            |                                                                                                            |
| <b>Note:</b> Services where plan deductible applies are noted with a caret (^).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                            |                                                                                                            |

01/01/2026

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Open Access Plus HDHPQ - HDHPQ Low

| Plan Highlights                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | In-Network                                                                                               | Out-of-Network                                                                                             |
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| <b>Plan Out-of-Pocket Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Individual - Employee Only: \$7,500<br>Individual - within a Family: \$7,500<br>Family Maximum: \$15,000 | Individual - Employee Only: \$15,000<br>Individual - within a Family: \$15,000<br>Family Maximum: \$30,000 |
| <ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</li> <li>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.</li> <li>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.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul> |  |                                                                                                          |                                                                                                            |
| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | In-Network                                                                                               | Out-of-Network                                                                                             |
| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                          |                                                                                                            |
| <b>Physician Services - Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                          |                                                                                                            |
| <b>Primary Care Physician (PCP) Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | Plan pays 70% ^                                                                                          | Plan pays 50% ^                                                                                            |
| <b>Specialty Care Physician Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Plan pays 70% ^                                                                                          | Plan pays 50% ^                                                                                            |
| <b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                          |                                                                                                            |
| <b>Surgery Performed in Physician's Office</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | Covered same as Physician Services - Office Visit                                                        | Covered same as Physician Services - Office Visit                                                          |
| <b>Allergy Treatment/Injections and Allergy Serum</b><br>Allergy serum dispensed by the physician in the office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | Covered same as Physician Services - Office Visit                                                        | Covered same as Physician Services - Office Visit                                                          |
| <b>Virtual Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                          |                                                                                                            |
| <b>Dedicated Virtual Providers - MDLIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                          |                                                                                                            |
| <b>MDLIVE Urgent Virtual Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Plan pays 70% ^                                                                                          | Not Covered                                                                                                |
| <b>MDLIVE Primary Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Plan pays 70% ^                                                                                          | Not Covered                                                                                                |
| <b>MDLIVE Specialty Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Plan pays 70% ^                                                                                          | Not Covered                                                                                                |
| <ul style="list-style-type: none"> <li>Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.</li> <li>For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).</li> <li>Lab services supporting a virtual visit must be obtained through dedicated labs.</li> <li>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                          |                                                                                                            |

| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                         | In-Network      | Out-of-Network                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-------------------------------------------------------------------------|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                                                                                                                                                                                                                                                                               |                 |                                                                         |
| <b>Virtual Physician Services - Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                 |                                                                         |
| <b>Primary Care Physician (PCP) Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                       | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <b>Specialty Care Physician Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                           | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <ul style="list-style-type: none"> <li>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</li> <li>Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.</li> </ul> |                 |                                                                         |
| <b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).                                                                                                                                                                                                                                                            |                 |                                                                         |
| <b>Convenience Care Clinic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 |                                                                         |
| <b>Convenience Care Clinic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <b>Preventive Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |                                                                         |
| <b>Preventive Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | Plan pays 100%  | Not Covered                                                             |
| <ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                                                                                       |                 |                                                                         |
| <b>Immunizations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            | Plan pays 100%  | Not Covered                                                             |
| <b>Mammogram, PAP, and PSA Tests</b>                                                                                                                                                                                                                                                                                                                                                                                                                            | Plan pays 100%  | Covered same as other x-ray and lab services, based on Place of Service |
| <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.</li> <li>Associated wellness exam is covered in-network only.</li> </ul>                                                                                                                        |                 |                                                                         |
| <b>Inpatient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |                                                                         |
| <b>Inpatient Hospital Facility Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs                                                                                                                                                                                                                                                                                                                           |                 |                                                                         |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>                                                                                                                                                                                                                                                                                                                                                                                                        | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <b>Inpatient Professional Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                          | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>                                                                                                                                                                                                                                                                                                                          |                 |                                                                         |
| <b>Outpatient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |                                                                         |
| <b>Outpatient Facility Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <b>Outpatient Professional Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | Plan pays 70% ^ | Plan pays 50% ^                                                         |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>                                                                                                                                                                                                                                                                                                                          |                 |                                                                         |

| Benefit                                                                                                                                                                                                                              | In-Network                                        | Out-of-Network                                    |
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| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                                                    |                                                   |                                                   |
| <b>Emergency Services</b>                                                                                                                                                                                                            |                                                   |                                                   |
| <b>Emergency Room</b><br><ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.</li> </ul>                      | Plan pays 70% ^                                   | Plan pays 70% ^                                   |
| <b>Urgent Care Facility</b><br><ul style="list-style-type: none"> <li>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.</li> </ul> | Plan pays 70% ^                                   | Plan pays 70% ^                                   |
| <b>Ambulance</b><br>Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.                                                                                | Plan pays 70% ^                                   | Plan pays 70% ^                                   |
| <b>Ambulance - Mental Health and Substance Use Disorder</b><br>Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.                                     | Plan pays 70% ^                                   | Plan pays 70% ^                                   |
| <b>Inpatient Services at Other Health Care Facilities</b>                                                                                                                                                                            |                                                   |                                                   |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b><br><ul style="list-style-type: none"> <li>Annual Limit: 60 days</li> </ul>                                                                            | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Laboratory Services</b>                                                                                                                                                                                                           |                                                   |                                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                                                             | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Independent Lab</b>                                                                                                                                                                                                               | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Outpatient Facility</b>                                                                                                                                                                                                           | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Radiology Services</b>                                                                                                                                                                                                            |                                                   |                                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                                                             | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Outpatient Facility</b>                                                                                                                                                                                                           | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Advanced Radiological Imaging (ARI)</b>                                                                                                                                                                                           | Includes MRI, MRA, CAT Scan, PET Scan, etc.       |                                                   |
| <b>Outpatient Facility</b>                                                                                                                                                                                                           | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                                                             | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |

| Benefit                                                                                                                                                                                                                                                                                                                              | In-Network                                        | Out-of-Network                                    |
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| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                                                                                                                                                    |                                                   |                                                   |
| <b>Outpatient Therapy Services</b>                                                                                                                                                                                                                                                                                                   |                                                   |                                                   |
| <b>Outpatient Therapy Services</b>                                                                                                                                                                                                                                                                                                   | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limits: <ul style="list-style-type: none"> <li>All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul> |                                                   |                                                   |
| <b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.                                                                                                                                                                                  |                                                   |                                                   |
| <b>Chiropractic Services</b>                                                                                                                                                                                                                                                                                                         | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit: <ul style="list-style-type: none"> <li>Chiropractic Care - 30 days</li> </ul>                                                                                                                                                                                                                                          |                                                   |                                                   |
| <b>Cardiac Rehabilitation Services</b>                                                                                                                                                                                                                                                                                               | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit: <ul style="list-style-type: none"> <li>Cardiac Rehabilitation - 36 days</li> </ul>                                                                                                                                                                                                                                     |                                                   |                                                   |
| <b>Hospice</b>                                                                                                                                                                                                                                                                                                                       |                                                   |                                                   |
| <b>Inpatient Facilities</b>                                                                                                                                                                                                                                                                                                          | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Outpatient Services</b>                                                                                                                                                                                                                                                                                                           | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.                                                                                                                                                                                                                                                  |                                                   |                                                   |
| <b>Bereavement Counseling (for services not provided as part of a hospice program)</b>                                                                                                                                                                                                                                               |                                                   |                                                   |
| Services Provided by a Mental Health Professional                                                                                                                                                                                                                                                                                    | Covered under Mental Health benefit               | Covered under Mental Health benefit               |
| <b>Medical Pharmaceutical Drugs</b>                                                                                                                                                                                                                                                                                                  |                                                   |                                                   |
| <b>Outpatient Facility</b>                                                                                                                                                                                                                                                                                                           | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Physician's Office</b>                                                                                                                                                                                                                                                                                                            | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Home</b>                                                                                                                                                                                                                                                                                                                          | Plan pays 70% ^                                   | Plan pays 50% ^                                   |
| <b>Note:</b> This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.                                                                                                                                               |                                                   |                                                   |

| Benefit                                                                                                                                                                                          | In-Network                                                      | Out-of-Network                                                  |
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| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                |                                                                 |                                                                 |
| <b>Maternity</b>                                                                                                                                                                                 |                                                                 |                                                                 |
| <b>Initial Visit to Confirm Pregnancy</b>                                                                                                                                                        | Covered same as Physician Services - Office Visit               | Covered same as Physician Services - Office Visit               |
| <b>All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges</b> (Global Maternity Fee)                                                                                  | Plan pays 70% ^                                                 | Plan pays 50% ^                                                 |
| <b>Office Visits in Addition to Global Maternity Fee</b> (Performed by OB/GYN or Specialist)                                                                                                     | Covered same as Physician Services - Office Visit               | Covered same as Physician Services - Office Visit               |
| <b>Delivery - Facility</b> (Inpatient Hospital, Birthing Center)                                                                                                                                 | Covered same as plan's Inpatient Hospital benefit               | Covered same as plan's Inpatient Hospital benefit               |
| <b>Abortion</b>                                                                                                                                                                                  |                                                                 |                                                                 |
| <b>Abortion Services</b><br><b>Note:</b> Elective and non-elective procedures                                                                                                                    | Plan pays 100%                                                  | Plan pays 100%                                                  |
| <b>Family Planning</b>                                                                                                                                                                           |                                                                 |                                                                 |
| <b>Women's Services</b><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                       |
| <b>Men's Services</b><br>Includes surgical sterilization services, such as vasectomy (excludes reversals)                                                                                        | Plan pays 100% ^                                                | Coverage varies based on Place of Service                       |
| <b>Infertility</b>                                                                                                                                                                               |                                                                 |                                                                 |
| <b>Fertility and Conception Treatment</b>                                                                                                                                                        | Coverage varies based on Place of Service                       | Coverage varies based on Place of Service                       |
| Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.<br>• Lifetime Maximum: \$10,000 |                                                                 |                                                                 |
| <b>Outpatient Dialysis Services</b>                                                                                                                                                              |                                                                 |                                                                 |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                         | Covered same as Physician Services - Office Visit               | Covered same as Physician Services - Office Visit               |
| <b>Home Dialysis</b><br><b>Note:</b> Dialysis visits will not accumulate to Home Health Care maximum                                                                                             | Covered same as plan's Home Health Care benefit                 | Covered same as plan's Home Health Care benefit                 |
| <b>Outpatient Facility Services</b>                                                                                                                                                              | Covered same as plan's Outpatient Facility Services benefit     | Covered same as plan's Outpatient Facility Services benefit     |
| <b>Outpatient Professional Services</b>                                                                                                                                                          | Covered same as plan's Outpatient Professional Services benefit | Covered same as plan's Outpatient Professional Services benefit |

| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | In-Network                                | Out-of-Network                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                           |                                           |
| <b>Other Health Care Facilities/Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |                                           |
| <b>Home Health Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Plan pays 70% ^                           | Plan pays 50% ^                           |
| <ul style="list-style-type: none"> <li>Annual Limit: 100 days (The limit is not applicable to mental health and substance use disorder conditions.)</li> <li>16 hour maximum per day</li> </ul>                                                                                                                                                                                                                                                                                                                                                                         |                                           |                                           |
| <b>Note:</b> Includes outpatient private duty nursing when approved as medically necessary                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |                                           |
| <b>Organ Transplants</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                           |                                           |
| <b>Inpatient Hospital Facility Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                           |                                           |
| LifeSOURCE Transplant Network® facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Plan pays 100% ^                          | Not Applicable                            |
| Other Facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Not Covered                               | Not Covered                               |
| <b>Inpatient Professional Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |                                           |
| LifeSOURCE Transplant Network® facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Plan pays 100% ^                          | Not Applicable                            |
| Other Facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Not Covered                               | Not Covered                               |
| <ul style="list-style-type: none"> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: After the plan deductible is met, \$10,000 maximum per Transplant per Lifetime</li> </ul>                                                                                                                                                                                                                                                                                                                                                                   |                                           |                                           |
| <b>Durable Medical Equipment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Plan pays 70% ^                           | Plan pays 50% ^                           |
| <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                           |                                           |
| <b>Breast Feeding Equipment and Supplies</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Plan pays 100%                            | Not Covered                               |
| <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                         |                                           |                                           |
| <b>External Prosthetic Appliances (EPA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan pays 70% ^                           | Plan pays 50% ^                           |
| <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                           |                                           |
| <b>Temporomandibular Joint Disorder (TMJ)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| <ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                           |                                           |
| <b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                           |                                           |
| <b>Routine Foot Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Not Covered                               | Not Covered                               |
| <b>Note:</b> Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.                                                                                                                                                                                                                                                                                                                                                                                                                          |                                           |                                           |
| <b>Travel Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Plan pays 100% ^                          | Not Covered                               |
| <ul style="list-style-type: none"> <li>Authorized eligible travel and lodging expenses when an In-network facility/provider is not available within a 60 mile radius from your primary home residence.</li> <li>Coverage for designated services only: services with state legislative limitations on access (e.g., abortion, gender affirmation services), In-patient and Outpatient Mental Health and Substance Use Disorder Services</li> <li>Coverage when traveling to an in-network provider/facility only</li> <li>Medical Lifetime Maximum: \$10,000</li> </ul> |                                           |                                           |

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**Benefit****In-Network****Out-of-Network**

**Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.**

**Mental Health and Substance Use Disorder**

|                                                                       |                 |                 |
|-----------------------------------------------------------------------|-----------------|-----------------|
| <b>Inpatient Mental Health</b>                                        | Plan pays 70% ^ | Plan pays 50% ^ |
| <b>Outpatient Mental Health – Physician’s Office</b>                  | Plan pays 70% ^ | Plan pays 50% ^ |
| <b>Outpatient Mental Health - MDLIVE Behavioral Services</b>          | Plan pays 70%   | Not Covered     |
| <b>Outpatient Mental Health – All Other Services</b>                  | Plan pays 70% ^ | Plan pays 50% ^ |
| <b>Inpatient Substance Use Disorder</b>                               | Plan pays 70% ^ | Plan pays 50% ^ |
| <b>Outpatient Substance Use Disorder – Physician’s Office</b>         | Plan pays 70% ^ | Plan pays 50% ^ |
| <b>Outpatient Substance Use Disorder - MDLIVE Behavioral Services</b> | Plan pays 70%   | Not Covered     |
| <b>Outpatient Substance Use Disorder – All Other Services</b>         | Plan pays 70% ^ | Plan pays 50% ^ |

**Annual Limits:**

- Unlimited maximum

**Notes:**

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office and MDLIVE Behavioral Services - 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****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<sup>SM</sup> program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.

## Pharmacy

## In-Network

### Cost Share and Supply

#### Cigna Pharmacy Cost Share

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply

#### Retail (per 30-day supply):

Generic: You pay \$10 <sup>^</sup>  
 Preferred Brand: You pay \$30 <sup>^</sup>  
 Non-Preferred Brand: You pay \$50 <sup>^</sup>

#### Retail (per 90-day supply):

Generic: You pay \$25 <sup>^</sup>  
 Preferred Brand: You pay \$85 <sup>^</sup>  
 Non-Preferred Brand: You pay \$145 <sup>^</sup>

#### Home Delivery (per 90-day supply):

Generic: You pay \$20 <sup>^</sup>  
 Preferred Brand: You pay \$60 <sup>^</sup>  
 Non-Preferred Brand: You pay \$100 <sup>^</sup>

- **Cigna 90 Now CVS:** 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. Walgreens will be considered out-of-network for a 90-day supply.
- 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.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- 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 annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.
- 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<sup>SM</sup> Pharmacy.

## Pharmacy

## In-Network

### Preventive Drugs:

Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network Generic and Preferred Brand preventive drugs and products included in the Preventive Plus Package will not be subject to deductible and 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

## Drugs Covered

### Prescription Drug List:

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

Some highlights:

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

## 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.

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## Pharmacy Program Information

### 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.

### Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- 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 (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.

## 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.

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

In-Network: Coordinated by your physician

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

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

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

In-Network: Coordinated by your physician

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

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

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

## Definitions

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

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

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

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

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

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

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

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

## Exclusions

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

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

- Care 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.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you 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. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - o not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - o not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - o the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - o the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose

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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.

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an 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.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- 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.
- 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 "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.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post 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 prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses 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 or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

### These are only the highlights

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

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EHB State: CA

# Discrimination is against the law.

## Medical coverage

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

### Cigna Healthcare:

- 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 Healthcare 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 Healthcare

Nondiscrimination Complaint Coordinator  
P.O. 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  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, 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). ATENCION: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. 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).

## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare 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 Healthcare, 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 Healthcare 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 Healthcare, 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 Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711) 번으로 전화해주시십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, 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 Healthcare, 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 Healthcare 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 Healthcare 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 Healthcare, 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 Healthcare 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 Healthcare 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 Healthcare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 Healthcare 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 Healthcare-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 می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره ای 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 شماره گیری کنید).