



1. Your employer\* will complete section A.
2. Complete sections B through G.
3. If you are electing dental coverage, complete the section entitled "DENTAL OPTIONS."
4. If you are electing medical, complete the section entitled "MEDICAL OPTIONS."
5. Read the information on the back of the enrollment/change form.
6. Sign and date the enrollment/change.

*We look forward to having you as our customer.*

**\*PLEASE NOTE:** This application is for open enrollment in medical, dental and vision coverage for **C-Level Associates, dba American Association of Executives, an Association.** There is no cost to join the association and there is a separate form to become a member in that association.

In the application where it refers to **"employer"** it refers to C-Level Associates, dba American Association of Executives, the Association. Where the application uses the term **"employee"** it refers to you as a member of the association.

For more information on the American Association of Executives, go to: <https://www.execaa.com/>

Send this completed application to Michael McCormick at CBR at [mmccormick@cbri.com](mailto:mmccormick@cbri.com). For more information, contact Michael at 480-540-6506 or Leticia Reynosa at (623) 688-3934.

Employer: Complete Section A Employee: Complete Section B-G



Enrollment/Change Form

A	<input type="checkbox"/> OPEN ENROLL <input type="checkbox"/> CHANGE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) ____/____/____	ASSOCIATION NAME	DATE JOINED (MM/DD/CCYY) ____/____/____	PLAN NUMBER 627871	SUBGROUP	CLASS
	<input type="checkbox"/> NEW ENROLL <input type="checkbox"/> REINSTATE						

B	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED ____/____/____	TYPE OF CHANGE <input type="checkbox"/> Add Dependent(s) * <input type="checkbox"/> Demographics <input type="checkbox"/> PCP Change <input type="checkbox"/> Retirement * List Name(s) in Section C <input type="checkbox"/> COBRA Continuation <input type="checkbox"/> Other _____ Qualifying Event Date: ____/____/____
	<input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	

C	EMPLOYEE NAME (Last)				(First)				SOCIAL SECURITY NUMBER			
	EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) ____/____/____				HOME PHONE (____) (____) (____) (____) (____) (____)				EMAIL ADDRESS			
	ADDRESS (Street)						(City)		(State)		(Zip Code)	
	<input type="checkbox"/> YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours)	Dependent Social Security Number	Date of Birth (MM/DD/CCYY)	Gender	Height	Weight	Coverage Selection	Full-Time Student?		Dental Late Entrant?		
	Last Name   First Name			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Employee	-   -	/   /				<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Dependent	Relationship	-   -	/   /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent	Relationship	-   -	/   /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Dependent	Relationship	-   -	/   /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Dependent	Relationship	-   -	/   /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med <input type="checkbox"/> Den <input type="checkbox"/> Vis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

ADDITIONAL INFORMATION- \* DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. \*\*PCP ID is required when the Medical Option selected below is Cigna SureFit®. If a PCP is not selected during enrollment one will be assigned. Otherwise PCP is optional.

D	MEDICAL OPTIONS:	
	<input type="checkbox"/>	HSA (with Banking)/ HSA
	<input type="checkbox"/>	Open Access Plus/ Base OAP
	<input type="checkbox"/>	Open Access Plus/ Buy up OAP
	<input type="checkbox"/>	LocalPlus®/ Local Plus
	<input type="checkbox"/>	Decline Coverage

E	DENTAL OPTIONS:		VISION OPTIONS:	
	<input type="checkbox"/>	Cigna Dental PPO/ DPPO	<input type="checkbox"/>	Cigna Vision/Vision
	<input type="checkbox"/>	Decline Coverage	<input type="checkbox"/>	Decline Coverage

F	OTHER HEALTHCARE COVERAGE:    Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please provide the following:									
	NAME OF PERSON COVERED		SOCIAL SECURITY NUMBER		EFFECTIVE DATE		MEDICARE Part A   Part B		MEDICAID	OTHER INSURANCE CARRIER
	-   -		-   -		/   /		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	
	-   -		-   -		/   /		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>	

**G**

The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand. **By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.**

EMPLOYEE SIGNATURE / DATE

## **PROVISIONS**

- Cigna Dental PPO plans are administered by CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries.
- I agree, for myself and my covered dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent permitted by state law.

## **FRAUD WARNING**

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

## **AUTHORIZATION TO DEDUCT CONTRIBUTIONS**

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

## **SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS**

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

age, disability, or sex, you can file a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# American Association of Executives

Effective Date: December 01, 2019

Cigna PLAN OFFERED	Open Access Plus OAP Buy UP	Open Access Plus OAP Base	New Plan LocalPlus LP Arizona Only	Cigna PLAN OFFERED	HSA Open Access Plus HSA OAP
Plan Offering Plan Name Medical Management Health Advocacy Funding	Quadruple Option OAP Buy Up (9403816) Included Excluded Level Funding	Quadruple Option OAP Base (9404009) Included Excluded Level Funding	Quadruple Option LP (9404150) Included Excluded Level Funding	Plan Offering Plan Name Medical Management Health Advocacy Funding	Quadruple Option HSA OAP (9403798) Included Excluded Level Funding
Cigna MEDICAL BENEFITS*				Cigna MEDICAL BENEFITS*	
Collective Deductible	NO	NO	NO	Collective Deductible	NO
Collective OOP	NO	NO	NO	Collective OOP	NO
Deductible/OOP Max Accumulator	No Cross Accumulation	No Cross Accumulation	No Cross Accumulation	Deductible/OOP Max Accumulator	No Cross Accumulation
Variable Coinsurance	NO	NO	NO	Variable Coinsurance	NO
Plan Deductible Order of Applicability	Benefit Copay, Plan Deductible, Coinsurance	Benefit Copay, Plan Deductible, Coinsurance	Benefit Copay, Plan Deductible, Coinsurance	Plan Deductible Order of Applicability	Plan Deductible, Benefit Copay, Coinsurance
<b>In-Network:</b>				<b>In-Network:</b>	
Office Copay - PCP	\$25	\$30	\$35	Office Copay - PCP	None
Office Copay - SPC	\$50	\$60	\$70	Office Copay - SPC	None
Inpatient Deductible - Per	NA	NA	NA	Deductible - Individual	\$4,000
Inpatient Deductible - Per	NA	NA	NA	Deductible - Family	\$8,000
Outpatient Facility Copay	None	None	None	Individual - In a Family Amount Deductible	\$4,000
Emergency Room Copay	\$250	\$300	\$400	Out-of-Pocket - Individual	\$6,000
Urgent Care Copay	\$75	\$75	\$100	Out-of-Pocket - Family	\$12,000
Deductible - Individual	\$2,000	\$3,000	\$4,000	Out-of-Pocket - Family - Individual Amount	\$6,000
Deductible - Family	\$4,000	\$6,000	\$8,000	Out-of-Pocket Max Deductible	Ded Accumulates
Out-of-Pocket - Individual	\$4,000	\$6,000	\$7,350	Out-of-Pocket Max Copays	All Copays Accumulate
Out-of-Pocket - Family	\$8,000	\$12,000	\$14,700	Coinsurance	80%
Out-of-Pocket - Family - Individual Amount	\$4,000	\$6,000	\$7,350	Adult Preventive Care Office Visit	100%, No Ded
Out-of-Pocket Max	Ded Accumulates	Ded Accumulates	Ded Accumulates	<b>Out of Network:</b>	
Out-of-Pocket Max Copays Coinsurance	All Copays Accumulate 100%	All Copays Accumulate 80%	All Copays Accumulate 90%	Deductible - Individual	\$8,000
<b>Out of Network:</b>				Deductible - Family	\$16,000
Deductible - Individual	\$4,000	\$6,000	\$8,000	Individual - In a Family Amount Deductible	\$8,000
Deductible - Family	\$8,000	\$12,000	\$16,000	Out-of-Pocket - Individual	\$16,000
Out-of-Pocket - Individual	\$8,000	\$12,000	\$20,000	Out-of-Pocket - Family	\$32,000
Out-of-Pocket - Family	\$16,000	\$24,000	\$40,000	Out-of-Pocket - Family - Individual Amount	\$16,000
Out-of-Pocket - Family - Individual Amount	\$8,000	\$12,000	\$20,000	Out-of-Pocket Max	Ded Accumulates
Out-of-Pocket Max	Ded Accumulates	Ded Accumulates	Ded Accumulates	Out-of-Pocket Max Copays	All Copays Accumulate
Out-of-Pocket Max Copays	All Copays Accumulate	All Copays Accumulate	All Copays Accumulate	Coinsurance	60%
Coinsurance	70%	60%	60%	MRC Fee Schedule	110%
Maximum Reimbursable Charge	Option 2	Option 2	Option 2	Percentage (Professional)	110%
Inpatient Deductible - Per	NA	NA	NA	MRC Fee Schedule Percentage	
Inpatient Deductible - Per	NA	NA	NA	<b>Pharmacy Benefits</b>	
Outpatient Facility	None	None	None	Pharmacy Network	Focused 90 - CVS
MRC Fee Schedule	110%	110%	110%	Formulary/PDL	Advantage
Percentage (Professional)	110%	110%	110%	Retail Copay	\$15/\$35/\$65
MRC Fee Schedule Percentage				Retail Copay (90 Days)	\$45/\$105/\$195
<b>Pharmacy Benefits</b>				Home Delivery Drug Copay	\$45/\$105/\$195
Pharmacy Network	Focused 90 - CVS	Focused 90 - CVS	Focused 90 - CVS	Deductible	Combined With Medical
Formulary/PDL	Advantage	Advantage	Advantage	Out-of-Pocket Max	Combined With Medical
Retail Copay	\$15/\$35/\$65	\$15/\$45/\$70	\$15/\$45/\$75	Out of Pocket Adjuster	Excluded
Retail Copay (90 Days)	\$45/\$105/\$195	\$45/\$135/\$210	\$45/\$135/\$225	<b>Mental Health/Substance Use Disorder (Yes/No)</b>	Yes
Home Delivery Drug Copay	\$45/\$105/\$195	\$45/\$135/\$210	\$45/\$135/\$225	<b>Vision Rider (Yes/No)</b>	No
Deductible	None (\$0)	None (\$0)	None (\$0)	<b>Employer Fund</b>	
Out-of-Pocket Max	Combined With Medical	Combined With Medical	Combined With Medical	Fund Amount - Individual	\$0
Out of Pocket Adjuster	Excluded	Excluded	Excluded	Fund Amount - Family	\$0
<b>Mental Health/Substance Use Disorder (Yes/No)</b>	Yes	Yes	Yes	Eligible Expense	NA
<b>Vision Rider (Yes/No)</b>	No	No	No		
<b>Employee</b>	\$917.54	\$819.47	\$699.06	<b>Employee</b>	\$680.10
<b>Employee + Spouse</b>	\$1,926.81	\$1,720.84	\$1,467.98	<b>Employee + Spouse</b>	\$1,428.18
<b>Employee + Child(ren)</b>	\$1,743.31	\$1,556.95	\$1,328.19	<b>Employee + Child(ren)</b>	\$1,292.17
<b>Employee + Family</b>	\$2,752.57	\$2,458.34	\$2,097.13	<b>Employee + Family</b>	\$2,040.26

## SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**  
**For - C-Level Associates, dba American Association of Executives**  
**LocalPlus Plan**



**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
<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	
<b>Plan Coinsurance</b>	Plan pays 90%	Plan pays 60%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Plan Deductible</b>	Individual: \$4,000 Family: \$8,000	Individual: \$8,000 Family: \$16,000
<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>Benefit copays/deductibles always apply before plan deductible and coinsurance.</li> <li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		



Plan Highlights		In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>		Individual: \$7,350 Family: \$14,700	Individual: \$20,000 Family: \$40,000
<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 (^). Benefit copays/deductibles always apply before plan deductible.</b>			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		\$35 copay, and plan pays 100%	Plan pays 60% ^
<b>Specialty Care Physician Services/Office Visit</b>		\$70 copay, and plan pays 100%	Plan pays 60% ^
<b>Surgery Performed in Physician's Office</b>		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Cigna Telehealth Connection Services</b>		\$35 copay, and plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li> </ul>			
<b>Preventive Care</b>			
<b>Preventive Care Office Visit</b>		Plan pays 100%	Not Covered
<b>Preventive Services</b>		Plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>			
<b>Immunizations</b>		Plan pays 100%	Not Covered
<b>Inpatient</b>			
<b>Inpatient Hospital Facility Services</b>		Plan pays 90% ^	Plan pays 60% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs			
<b>Inpatient Hospital Physician's Visit/Consultation</b>		Plan pays 90% ^	Plan pays 60% ^
<b>Inpatient Professional Services</b>		Plan pays 90% ^	Plan pays 60% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>			
<b>Outpatient</b>			

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Facility Services	Plan pays 90% ^	Plan pays 60% ^
Outpatient Professional Services <ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>	Plan pays 90% ^	Plan pays 60% ^
Emergency Services		
Emergency Room <ul style="list-style-type: none"><li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li><li>Per visit copay is waived if admitted.</li></ul>	\$400 copay, and plan pays 100%	
Urgent Care Facility Includes Physician Charges, Lab and Radiology	\$100 copay, and plan pays 100%	Plan pays 60% ^
Ambulance Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 90% ^	
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities <ul style="list-style-type: none"><li>Annual Limit: 60 days</li></ul>	Plan pays 90% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 90% ^	Plan pays 60% ^
Physician's Services/Office Visit	Plan pays 90% ^	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Outpatient Short Term Rehabilitation</b>		
<b>Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy</b>	\$70 copay, and plan pays 100%	Plan pays 60% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul>		
<b>Note:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Chiropractic Care</b>	\$70 copay, and plan pays 100%	Plan pays 60% ^
Annual Limit:		
<ul style="list-style-type: none"> <li>Chiropractic Care – 20 visits</li> </ul>		
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Outpatient Services</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Physician's Office</b>	Plan pays 100%	Plan pays 60% ^
<b>Home</b>	Plan pays 90% ^	Plan pays 60% ^
<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.		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Not Covered
In-Network includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals). Out-of-Network coverage is provided for contraceptive devices as ordered or prescribed by a physician.		
<b>Men's Services</b>	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Infertility</b>		
<b>Infertility Treatment</b>		
<b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b>	Plan pays 90% ^	Plan pays 60% ^
<ul style="list-style-type: none"> <li>Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>		
<b>Organ Transplants</b>	Covered same as Inpatient benefit	Not Covered
<ul style="list-style-type: none"> <li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li> <li>Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: \$10,000 maximum per Transplant</li> </ul>		
<b>Durable Medical Equipment and External Prosthetic Appliances</b>	Plan pays 90% ^	Plan pays 60% ^
<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>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>Annual Limit: Unlimited for Surgical and Non-Surgical treatment</li> </ul>		
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient mental health</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Outpatient mental health – Physician's Office</b>	\$70 copay, and plan pays 100%	Plan pays 60% ^
<b>Outpatient mental health – all other services</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Inpatient substance use disorder</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Outpatient substance use disorder – Physician's Office</b>	\$70 copay, and plan pays 100%	Plan pays 60% ^
<b>Outpatient substance use disorder – all other services</b>	Plan pays 90% ^	Plan pays 60% ^
<b>Annual Limits:</b> <ul style="list-style-type: none"> <li>Unlimited maximum</li> </ul>		
<b>Notes:</b> <ul style="list-style-type: none"> <li>Inpatient includes Acute Inpatient and Residential Treatment.</li> <li>Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.</li> </ul>		

## Pharmacy

## In-Network

### Cost Share and Supply

#### Pharmacy Cost Share

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)
- If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.

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

Generic: You pay \$15  
Preferred Brand: You pay \$45  
Non-Preferred Brand: You pay \$75

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

Generic: You pay \$45  
Preferred Brand: You pay \$135  
Non-Preferred Brand: You pay \$225

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

Generic: You pay \$45  
Preferred Brand: You pay \$135  
Non-Preferred Brand: You pay \$225

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- 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 Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

## Drugs Covered

### Prescription Drug List:

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

Some highlights:

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

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

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

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

### Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all 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 as the Secondary plan to Medicare Part A and B as follows:

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

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

### Out-of-Area Services

- Coverage for services rendered outside a network area
- ER and Ambulance paid the same as network services
- Preventive care services covered at 100% for Out-of-Area
- Out-of-Network Deductible and Out-of-Pocket maximums apply

For all other services, plan pays 80% after the out-of-network deductible is met

### Complete Care Management

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

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

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans



## Exclusions

- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services

### These are only the highlights

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

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

EHB State: AZ



# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">in-network providers</a> : \$2,000/individual or \$4,000/family For <a href="#">out-of-network providers</a> : \$4,000/individual or \$8,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network <a href="#">preventive care</a> , office visits, <a href="#">diagnostic test</a> , <a href="#">prescription drugs</a> , emergency room visits, in-network <a href="#">urgent care</a> facility visits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> \$4,000/individual or \$8,000/family For <a href="#">out-of-network providers</a> \$8,000/individual or \$16,000/family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	No charge/visit** No charge/other services** No charge/immunizations**  ** <a href="#">Deductible</a> does not apply	Not covered/visit Not covered/other services Not covered/immunizations	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge at an outpatient facility No charge in the office	30% <a href="#">coinsurance</a> at an outpatient facility 30% <a href="#">coinsurance</a> in the office	\$750 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a></p>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /prescription (retail 30 days), \$45 <a href="#">copay</a> /prescription (retail 90 days); \$45 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	<p>Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Preferred brand drugs (Tier 2)	\$35 <a href="#">copay</a> /prescription (retail 30 days), \$105 <a href="#">copay</a> /prescription (retail 90 days); \$105 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$65 <a href="#">copay</a> /prescription (retail 30 days), \$195 <a href="#">copay</a> /prescription (retail 90 days); \$195 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$250 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> /office visit** No charge/all other services ** <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> /office visit 30% <a href="#">coinsurance</a> /all other services	\$750 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	No charge/admission	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.
If you are pregnant	Office visits	No charge	30% <a href="#">coinsurance</a>	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	30% <a href="#">coinsurance</a>	



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification. Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**  \$50 <a href="#">copay</a> /visit for Chiropractic care** ** <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> /visit for Physical, Speech, Hearing & Occupational therapy  30% <a href="#">coinsurance</a> /visit for Chiropractic care	\$750 penalty for failure to precertify speech therapy. Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**  \$50 <a href="#">copay</a> /visit for Chiropractic care** ** <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> /visit for Physical, Speech, Hearing & Occupational therapy  30% <a href="#">coinsurance</a> /visit for Chiropractic care	\$750 penalty for failure to precertify speech therapy.  Services are covered when Medically Necessary to treat a mental health condition (e.g. autism).  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification. Coverage is limited to 60 days annual max.
	<a href="#">Durable medical equipment</a>	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.
	<a href="#">Hospice services</a>	No charge	30% <a href="#">coinsurance</a>	\$750 penalty for no precertification.

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

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Children)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>• Chiropractic care (20 visits)</li> </ul>



### Your Rights to Continue Coverage:

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

### Your Grievance and Appeals Rights:

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

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-494-2111.

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

## About these Coverage Examples:



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

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

Total Example Cost	\$12,800
--------------------	----------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$40
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,050

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

Total Example Cost	\$7,400
--------------------	---------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$1,000

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

Total Example Cost	\$1,900
--------------------	---------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$630
Copayments	\$400
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,030

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

PAGE INTENTIONALLY BLANK

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**  
**For - C-Level Associates**  
**Open Access Plus Base**



**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
<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	
<b>Plan Coinsurance</b>	Plan pays 80%	Plan pays 60%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Plan Deductible</b>	Individual: \$3,000 Family: \$6,000	Individual: \$6,000 Family: \$12,000
<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>Benefit copays/deductibles always apply before plan deductible and coinsurance.</li> <li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

Plan Highlights		In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>		Individual: \$6,000 Family: \$12,000	Individual: \$12,000 Family: \$24,000
<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 (^). Benefit copays/deductibles always apply before plan deductible.</b>			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		\$30 copay, and plan pays 100%	Plan pays 60% ^
<b>Specialty Care Physician Services/Office Visit</b>		\$60 copay, and plan pays 100%	Plan pays 60% ^
<b>Surgery Performed in Physician's Office</b>		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Cigna Telehealth Connection Services</b>		\$30 copay, and plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li> </ul>			
<b>Preventive Care</b>			
<b>Preventive Care Office Visit</b>		Plan pays 100%	Not Covered
<b>Preventive Services</b>		Plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>			
<b>Immunizations</b>		Plan pays 100%	Not Covered
<b>Inpatient</b>			
<b>Inpatient Hospital Facility Services</b>		Plan pays 80% ^	Plan pays 60% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs			
<b>Inpatient Hospital Physician's Visit/Consultation</b>		Plan pays 80% ^	Plan pays 60% ^
<b>Inpatient Professional Services</b>		Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>			
<b>Outpatient</b>			

12/1/2019

ASO

Open Access Plus - 2019 OAP Base 12.01.2019



Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services <ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room <ul style="list-style-type: none"><li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li><li>Per visit copay is waived if admitted.</li></ul>	\$300 copay, and plan pays 100%	
Urgent Care Facility Includes Physician Charges, Lab and Radiology	\$75 copay, and plan pays 100%	Plan pays 60% ^
Ambulance Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities <ul style="list-style-type: none"><li>Annual Limit: 60 days</li></ul>	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^



Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Outpatient Short Term Rehabilitation</b>		
<b>Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy</b>	\$60 copay, and plan pays 100%	Plan pays 60% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul>		
<b>Note:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Chiropractic Care</b>	\$60 copay, and plan pays 100%	Plan pays 60% ^
Annual Limit:		
<ul style="list-style-type: none"> <li>Chiropractic Care – 20 visits</li> </ul>		
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Physician's Office</b>	Plan pays 100%	Plan pays 60% ^
<b>Home</b>	Plan pays 80% ^	Plan pays 60% ^
<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.		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Not Covered
In-Network includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals). Out-of-Network coverage is provided for contraceptive devices as ordered or prescribed by a physician.		
<b>Men's Services</b>	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		

12/1/2019

ASO

Open Access Plus - 2019 OAP Base 12.01.2019

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Infertility</b>		
<b>Infertility Treatment</b>		
<b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b>	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"> <li>Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>		
<b>Organ Transplants</b>	Covered same as Inpatient benefit	Not Covered
<ul style="list-style-type: none"> <li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li> <li>Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: \$10,000 maximum per Transplant</li> </ul>		
<b>Durable Medical Equipment and External Prosthetic Appliances</b>	Plan pays 80% ^	Plan pays 60% ^
<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>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>Annual Limit: Unlimited for Surgical and Non-Surgical treatment</li> </ul>		
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient mental health</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient mental health – Physician's Office</b>	\$60 copay, and plan pays 100%	Plan pays 60% ^
<b>Outpatient mental health – all other services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Inpatient substance use disorder</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient substance use disorder – Physician's Office</b>	\$60 copay, and plan pays 100%	Plan pays 60% ^
<b>Outpatient substance use disorder – all other services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Annual Limits:</b> <ul style="list-style-type: none"> <li>Unlimited maximum</li> </ul>		
<b>Notes:</b> <ul style="list-style-type: none"> <li>Inpatient includes Acute Inpatient and Residential Treatment.</li> <li>Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.</li> </ul>		

## Pharmacy

## In-Network

### Cost Share and Supply

#### Pharmacy Cost Share

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)
- If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.

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

Generic: You pay \$15  
Preferred Brand: You pay \$45  
Non-Preferred Brand: You pay \$70

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

Generic: You pay \$45  
Preferred Brand: You pay \$135  
Non-Preferred Brand: You pay \$210

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

Generic: You pay \$45  
Preferred Brand: You pay \$135  
Non-Preferred Brand: You pay \$210

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- 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 Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

## Drugs Covered

### Prescription Drug List:

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

Some highlights:

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

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

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

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

### Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all 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 as the Secondary plan to Medicare Part A and B as follows:

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

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

### One Guide

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

### Out-of-Area Services

- Coverage for services rendered outside a network area
- ER and Ambulance paid the same as network services
- Preventive care services covered at 100% for Out-of-Area
- Out-of-Network Deductible and Out-of-Pocket maximums apply

For all other services, plan pays 80% after the out-of-network deductible is met

### Complete Care Management

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

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

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document

12/1/2019

ASO

Open Access Plus - 2019 OAP Base 12.01.2019

## Exclusions

- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services

### **These are only the highlights**

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

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

EHB State: AZ

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.  
For - C-Level Associates  
Health Savings Account Open Access**



**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.

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

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Year Accumulation</b>	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated	
<b>Plan Coinsurance</b>	Plan pays 80%	Plan pays 60%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Plan Deductible</b>	Individual - Employee Only: \$4,000 Individual - within a Family: \$4,000 Family Maximum: \$8,000	Individual - Employee Only: \$8,000 Individual - within a Family: \$8,000 Family Maximum: \$16,000
<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>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> <li>This plan includes a combined Medical/Pharmacy plan deductible.</li> </ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

12/1/2019

ASO

Health Savings Account Open Access Plus - 2019 HSA OAP 12.01.2019

Plan Highlights		In-Network	Out-of-Network
Plan Out-of-Pocket Maximum		Individual - Employee Only: \$6,000 Individual - within a Family: \$6,000 Family Maximum: \$12,000	Individual - Employee Only: \$16,000 Individual - within a Family: \$16,000 Family Maximum: \$32,000
<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	
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.			
Physician Services - Office Visits			
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^	
Specialty Care Physician Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^	
Surgery Performed in Physician's Office	Plan pays 80% ^	Plan pays 60% ^	
Cigna Telehealth Connection Services	Plan pays 80% ^	Not Covered	
<ul style="list-style-type: none"><li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li></ul>			
Preventive Care			
Preventive Care Office Visit	Plan pays 100%	Not Covered	
Preventive Services	Plan pays 100%	Not Covered	
<ul style="list-style-type: none"><li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li><li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li></ul>			
Immunizations	Plan pays 100%	Not Covered	
Inpatient			
Inpatient Hospital Facility Services	Plan pays 80% ^	Plan pays 60% ^	
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs			
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^	
Inpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^	
<ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>			
Outpatient			

12/1/2019

ASO

Health Savings Account Open Access Plus - 2019 HSA OAP 12.01.2019

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.		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services <ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room <ul style="list-style-type: none"><li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li></ul>	Plan pays 80% ^	
Urgent Care Facility Includes Physician Charges, Lab and Radiology	Plan pays 80% ^	Plan pays 60% ^
Ambulance Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities <ul style="list-style-type: none"><li>Annual Limit: 60 days</li></ul>	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician’s Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician’s Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician’s Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Outpatient Short Term Rehabilitation		
Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy Annual Limits: <ul style="list-style-type: none"><li>All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits</li><li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li></ul>	Plan pays 80% ^	Plan pays 60% ^
Note: Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		

12/1/2019

ASO

Health Savings Account Open Access Plus - 2019 HSA OAP 12.01.2019

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>Chiropractic Care</b> Annual Limit: • Chiropractic Care – 20 visits	Plan pays 80% ^	Plan pays 60% ^
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Physician's Office</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Home</b>	Plan pays 80% ^	Plan pays 60% ^
<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.		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Not Covered
In-Network includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals). Out-of-Network coverage is provided for contraceptive devices as ordered or prescribed by a physician.		
<b>Men's Services</b>	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		
<b>Infertility</b>		
<b>Infertility Treatment</b>		
<b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> • Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)	Plan pays 80% ^	Plan pays 60% ^

12/1/2019

ASO

Health Savings Account Open Access Plus - 2019 HSA OAP 12.01.2019

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Organ Transplants</b> <ul style="list-style-type: none"><li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li><li>Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: \$10,000 maximum per Transplant</li></ul>	Covered same as Inpatient benefit	Covered same as Inpatient benefit
<b>Durable Medical Equipment and External Prosthetic Appliances</b> <ul style="list-style-type: none"><li>Annual Limit: Unlimited</li></ul>	Plan pays 80% ^	Plan pays 60% ^
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"><li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li><li>Includes related supplies</li></ul>	Plan pays 100%	Not Covered
<b>Temporomandibular Joint Disorder (TMJ)</b> <ul style="list-style-type: none"><li>Annual Limit: Unlimited for Surgical and Non-Surgical treatment</li></ul>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient mental health</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient mental health – Physician’s Office</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient mental health – all other services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Inpatient substance use disorder</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient substance use disorder – Physician’s Office</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient substance use disorder – all other services</b>	Plan pays 80% ^	Plan pays 60% ^
Annual Limits: <ul style="list-style-type: none"><li>Unlimited maximum</li></ul>		
<u>Notes:</u> <ul style="list-style-type: none"><li>Inpatient includes Acute Inpatient and Residential Treatment.</li><li>Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.</li><li>Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.</li></ul>		
Pharmacy	In-Network	
<b>Cost Share and Supply</b>		

## Pharmacy

### Med Pharmacy Cost Share

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)
- If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.

## In-Network

Once the medical deductible is met then the customer is responsible for the cost share

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

Generic: You pay \$15 ^

Preferred Brand: You pay \$35 ^

Non-Preferred Brand: You pay \$65 ^

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

Generic: You pay \$45 ^

Preferred Brand: You pay \$105 ^

Non-Preferred Brand: You pay \$195 ^

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- 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 Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- You can elect brand or generic with no penalty (MAC C).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- 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.

## Drugs Covered

### Prescription Drug List:

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

Some highlights:

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

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

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

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

### Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all 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 as the Secondary plan to Medicare Part A and B as follows:

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

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

### One Guide

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

### Out-of-Area Services

- Coverage for services rendered outside a network area
- ER and Ambulance paid the same as network services
- Preventive care services covered at 100% for Out-of-Area
- In-Network Deductible and Out-of-Pocket maximums apply

For all other services, plan pays 80% after the in-network deductible is met

### Complete Care Management

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

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

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document

12/1/2019

ASO

Health Savings Account Open Access Plus - 2019 HSA OAP 12.01.2019

## Exclusions

- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services

### These are only the highlights

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

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

EHB State: AZ

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**  
**For - C-Level Associates**  
**Open Access Plus Buy Up**



**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
<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	
<b>Plan Coinsurance</b>	Plan pays 100%	Plan pays 70%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Plan Deductible</b>	Individual: \$2,000 Family: \$4,000	Individual: \$4,000 Family: \$8,000
<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>Benefit copays/deductibles always apply before plan deductible and coinsurance.</li> <li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

Plan Highlights		In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>		Individual: \$4,000 Family: \$8,000	Individual: \$8,000 Family: \$16,000
<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 (^). Benefit copays/deductibles always apply before plan deductible.</b>			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		\$25 copay, and plan pays 100%	Plan pays 70% ^
<b>Specialty Care Physician Services/Office Visit</b>		\$50 copay, and plan pays 100%	Plan pays 70% ^
<b>Surgery Performed in Physician's Office</b>		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Cigna Telehealth Connection Services</b>		\$25 copay, and plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)</li> </ul>			
<b>Preventive Care</b>			
<b>Preventive Care Office Visit</b>		Plan pays 100%	Not Covered
<b>Preventive Services</b>		Plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>			
<b>Immunizations</b>		Plan pays 100%	Not Covered
<b>Inpatient</b>			
<b>Inpatient Hospital Facility Services</b>		Plan pays 100% ^	Plan pays 70% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs			
<b>Inpatient Hospital Physician's Visit/Consultation</b>		Plan pays 100% ^	Plan pays 70% ^
<b>Inpatient Professional Services</b>		Plan pays 100% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>			
<b>Outpatient</b>			

12/1/2019

ASO

Open Access Plus - 2019 OAP Buy Up 12.01.2019



Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Facility Services	Plan pays 100% ^	Plan pays 70% ^
Outpatient Professional Services	Plan pays 100% ^	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Emergency Services		
Emergency Room	\$250 copay, and plan pays 100%	
• Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)		
• Per visit copay is waived if admitted.		
Urgent Care Facility	\$75 copay, and plan pays 100%	Plan pays 70% ^
Includes Physician Charges, Lab and Radiology		
Ambulance	Plan pays 100% ^	
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities	Plan pays 100% ^	Plan pays 70% ^
• Annual Limit: 60 days		
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 70% ^
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Physician's Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^



Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Outpatient Short Term Rehabilitation</b>		
<b>Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy</b>	\$50 copay, and plan pays 100%	Plan pays 70% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul>		
<b>Note:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
<b>Chiropractic Care</b>	\$50 copay, and plan pays 100%	Plan pays 70% ^
Annual Limit:		
<ul style="list-style-type: none"> <li>Chiropractic Care – 20 visits</li> </ul>		
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Outpatient Services</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Physician's Office</b>	Plan pays 100%	Plan pays 70% ^
<b>Home</b>	Plan pays 100% ^	Plan pays 70% ^
<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.		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Not Covered
In-Network includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals). Out-of-Network coverage is provided for contraceptive devices as ordered or prescribed by a physician.		
<b>Men's Services</b>	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		

12/1/2019

ASO

Open Access Plus - 2019 OAP Buy Up 12.01.2019

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Infertility</b>		
<b>Infertility Treatment</b>		
<b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b>	Plan pays 100% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>		
<b>Organ Transplants</b>	Covered same as Inpatient benefit	Not Covered
<ul style="list-style-type: none"> <li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li> <li>Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: \$10,000 maximum per Transplant</li> </ul>		
<b>Durable Medical Equipment and External Prosthetic Appliances</b>	Plan pays 100% ^	Plan pays 70% ^
<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>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>Annual Limit: Unlimited for Surgical and Non-Surgical treatment</li> </ul>		
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient mental health</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Outpatient mental health – Physician's Office</b>	\$50 copay, and plan pays 100%	Plan pays 70% ^
<b>Outpatient mental health – all other services</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Inpatient substance use disorder</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Outpatient substance use disorder – Physician's Office</b>	\$50 copay, and plan pays 100%	Plan pays 70% ^
<b>Outpatient substance use disorder – all other services</b>	Plan pays 100% ^	Plan pays 70% ^
<b>Annual Limits:</b> <ul style="list-style-type: none"> <li>Unlimited maximum</li> </ul>		
<b>Notes:</b> <ul style="list-style-type: none"> <li>Inpatient includes Acute Inpatient and Residential Treatment.</li> <li>Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.</li> </ul>		

12/1/2019

ASO

Open Access Plus - 2019 OAP Buy Up 12.01.2019

## Pharmacy

## In-Network

### Cost Share and Supply

#### Pharmacy Cost Share

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)
- If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.

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

Generic: You pay \$15  
Preferred Brand: You pay \$35  
Non-Preferred Brand: You pay \$65

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

Generic: You pay \$45  
Preferred Brand: You pay \$105  
Non-Preferred Brand: You pay \$195

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

Generic: You pay \$45  
Preferred Brand: You pay \$105  
Non-Preferred Brand: You pay \$195

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- 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 Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When you request a brand drug, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW) (MAC B).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

## Drugs Covered

### Prescription Drug List:

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

Some highlights:

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

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

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

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

### Clinical Outcome Programs:

- Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history.

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all 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 as the Secondary plan to Medicare Part A and B as follows:

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

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

### One Guide

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

### Out-of-Area Services

- Coverage for services rendered outside a network area
- ER and Ambulance paid the same as network services
- Preventive care services covered at 100% for Out-of-Area
- Out-of-Network Deductible and Out-of-Pocket maximums apply

For all other services, plan pays 80% after the out-of-network deductible is met

### Complete Care Management

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

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

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document

12/1/2019

ASO

Open Access Plus - 2019 OAP Buy Up 12.01.2019

## Exclusions

- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services

### These are only the highlights

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

*All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.*

EHB State: AZ

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

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

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# C-Level Associates, dba American Association of Executives - DPPO

Effective Date: January 01, 2020



This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	\$1500, Class I Applies	\$1500, Class I Applies
Calendar Year Deductible		
Per Individual	\$50	\$50
Per Family	\$150	\$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
Coverage for Eligible Children Only Lifetime Maximum	50%, No Ortho Deductible \$1000	50%, No Ortho Deductible \$1000
Dental Plan Reimbursement Levels		
	Based on Contracted Fees	90th Percentile
Additional Member Responsibility in excess of Coinsurance		
	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age		
	26/26	
Rates:		

Employee	\$38.76
Employee + Spouse	\$76.95
Employee + Child(ren)	\$100.30
Employee + Family	\$151.06

# C-Level Associates - DPPO

Effective Date: January 01, 2020



## Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 per 36 consecutive months. Panorax: 1 per 36 consecutive months
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	1 per 60 consecutive months
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	1 per 60 consecutive months
Dentures and Partial	1 per 60 consecutive months
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Orthodontia	For dependent children, up to age 19
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for 12 months; thereafter, considered a Class III expense
Late Entrant Limit	50% coverage on Class III and IV (if applicable), for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of \$200 is proposed

## Benefit Exclusions:

- \* Services performed primarily for cosmetic reasons
- \* Replacement of a lost or stolen appliance
- \* Replacement of a bridge or denture within five years following the date of its original installation
- \* Replacement of a bridge or denture which can be made useable according to accepted dental standards
- \* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- \* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- \* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type
- \* Instruction for plaque control, oral hygiene and diet
- \* Dental services that do not meet common dental standards
- \* Services that are deemed to be medical services
- \* Services and supplies received from a hospital
- \* Charges which the person is not legally required to pay
- \* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- \* Experimental or investigational procedures and treatments
- \* Any injury resulting from, or in the course of, any employment for wage or profit
- \* Any sickness covered under any workers' compensation or similar law
- \* Charges in excess of the reasonable and customary allowances
- \* To the extent that payment is unlawful where the person resides when the expenses are incurred;
- \* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- \* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- \* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- \* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- \* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

**\*\* In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.**

*This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.*

**Benefits are insured and/or administered by Cigna HealthCare.**

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Cigna is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries.

*Prepared by Underwriting.*

Cigna DPPO Network (P0002 / NS001)

# DISCRIMINATION IS AGAINST THE LAW

## Dental coverage

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

Cigna:

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, 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). ATENCIÓN: 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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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

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

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

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 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, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

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

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

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

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

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

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

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

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

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

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



# Summary of Benefits Cigna Health and Life Insurance Company



## Cigna Vision C-Level Associates, dba American Association of Executives C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	In-Network Benefit***	Out-of-Network Benefit	Frequency Period **
Exam Copay	\$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to \$45	12 months
Materials Copay	\$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period)			
Single Vision	Covered 100% after Copay	Up to \$32	12 months
Lined Bifocal	Covered 100% after Copay	Up to \$55	12 months
Lined Trifocal	Covered 100% after Copay	Up to \$65	12 months
Lenticular	Covered 100% after Copay	Up to \$80	12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period)			
Elective	Up to \$130	Up to \$105	12 months
Therapeutic	Covered 100%	Up to \$210	12 months
Frame Retail Allowance (one per frequency period)	Up to \$130	Up to \$71	24 months
<b>Definitions:</b> <b>Copay:</b> the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses). <b>Coinsurance:</b> the percentage of charges Cigna will pay. Customer is financially responsible for the balance. <b>Allowance:</b> the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance. <b>Materials:</b> eyeglass lenses, frames, and/or contact lenses.			
<ul style="list-style-type: none"> <li>To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.</li> <li>If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.</li> </ul>			
<b>In-Network Coverage Includes***:</b> <ul style="list-style-type: none"> <li>One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;</li> <li>One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)               <ul style="list-style-type: none"> <li>Polycarbonate lenses for children under 19 years of age</li> <li>Oversize lenses</li> <li>Rose #1 and #2 solid tints</li> <li>Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.</li> <li>Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;</li> </ul> </li> </ul>			

Monthly Rates:

Employee Only: \$8.02

Employee + Spouse: \$14.93

Employee + Child(ren) \$15.08

Employee + Family \$23.40



- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

\* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

\*\*\* Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

#### **Healthy Rewards® - Vision Network Savings Program:**

- When you see a Cigna Vision Network Eye Care Professional\*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

#### **What's Not Covered:**

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

#### **How to use your Cigna Vision Benefits**

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

##### **1. Finding a doctor**

There are three ways to find a quality eye doctor in your area:



1. Log into myCigna.com, "Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

## **2. Schedule an appointment**

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

## **3. Out-of-network plan reimbursement**

### **How to use your Cigna Vision Benefits**

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Healthy Rewards® - Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.

## DISCRIMINATION IS AGAINST THE LAW

### Vision coverage

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

Cigna:

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

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

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

Cigna  
Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

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

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



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. Call 1.877.478.7557 (TTY: 800.428.4833). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.478.7557 (TTY: 800.428.4833).

896376a 05/17 © 2017 Cigna.

### Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.877.478.7557 (TTY: 800.428.4833).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.877.478.7557 (TTY: 800.428.4833).

**Chinese** – 注意：我們可為您免費提供語言協助服務。請致電 1.877.478.7557（聽障專線：800.428.4833）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.877.478.7557 (TTY: 800.428.4833).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.478.7557 (TTY: 800.428.4833)번으로 전화해주시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.877.478.7557 (TTY: 800.428.4833).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.478.7557 (линия ТТУ телетайп: 800.428.4833).

**Arabic** – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.478.7557 (رقم هاتف الصم والبكم: 800.428.4833).

**French Creole** – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.478.7557 (TTY: 800.428.4833).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.877.478.7557 (ATS: 800.428.4833).

**Portuguese** – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.877.478.7557 (TTY: 800.428.4833).

**Polish** – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 877 478 7557 (TTY: 800.428.4833).

**Japanese** – 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1.877.478.7557 (TTY: 800.428.4833) まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.478.7557 (TTY: 800.428.4833).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.478.7557 (TTY: 800.428.4833).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. با شماره 1.877.478.7557 تماس بگیرید (شماره تلفن ویژه ناشنوایان: 800.428.4833).



# MONTHLY PREMIUMS AND ENROLLMENT

Coverage Level	Cigna OAP - Base Plan
Executive Only	\$819.47
Executive + Spouse	\$1,720.84
Executive + Child (Ren)	\$1,556.95
Executive + Family	\$2,458.34
Coverage Level	Cigna OAP – Buy-Up Plan
Executive Only	\$917.54
Executive + Spouse	\$1,926.81
Executive + Child (Ren)	\$1,743.31
Executive + Family	\$2,752.57
Coverage Level	Cigna OAP – Local Plus Plan
Executive Only	\$699.06
Executive + Spouse	\$1,467.98
Executive + Child (Ren)	\$1,328.19
Executive + Family	\$2,097.13
Coverage Level	Cigna OAP – HDHP Plan (HSA)
Executive Only	\$680.10
Executive + Spouse	\$1,428.18
Executive + Child (Ren)	\$1,292.17
Executive + Family	\$2,040.26

Coverage Level	Cigna DPPO Dental
Executive Only	\$38.76
Executive + Spouse	\$76.95
Executive + Child (Ren)	\$100.30
Executive + Family	\$151.06

Coverage Level	Cigna Vision Plan
Executive Only	\$8.02
Executive + Spouse	\$14.93
Executive + Child (Ren)	\$15.08
Executive + Family	\$23.40