

## BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.  
For - Bi-State Development  
Open Access Plus Plan  
Premium Plan  
Effective - 01/01/2026



**Notice of Grandfathered Plan Status** This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on Cigna's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html). If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

**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.

**Behavioral Health for NM residents** - No Charge for in-network state mandated mental health, behavioral or substance use disorder diagnosis.

**A Notice for Missouri Residents:** This plan does not include an optional rider to cover elective abortions.

| 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. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. |                |
| <b>Plan Coinsurance</b>            | Plan pays 100%                                                                                                                                                                                                                                                                             | Plan pays 80%  |
| <b>Maximum Reimbursable Charge</b> | Not Applicable                                                                                                                                                                                                                                                                             | 110%           |

01/01/2026  
ASO  
Open Access Plus - Premium Plan

| Plan Highlights                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | In-Network                                        | Out-of-Network                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|---------------------------------------------------|
| <b>Plan Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Individual: None<br>Family: None                  | Individual: \$500<br>Family: \$1,000              |
| <ul style="list-style-type: none"> <li>The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.</li> <li>Benefit copays/deductibles always apply before plan deductible and coinsurance.</li> <li>Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</li> <li>Fourth quarter carryover feature applies</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                   |                                                   |
| <b>Note:</b> Services where plan deductible applies are noted with a caret (^).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                   |                                                   |
| <b>Plan Out-of-Pocket Maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Individual: None<br>Family: None                  | Individual: \$2,300<br>Family: \$4,600            |
| <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 do not 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>Fourth quarter carryover feature applies</li> </ul> |  |                                                   |                                                   |
| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | In-Network                                        | Out-of-Network                                    |
| <b>Note:</b> Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                   |                                                   |
| <b>Physician Services - Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |                                                   |
| <b>Primary Care Physician (PCP) Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | \$30 copay, and plan pays 100%                    | Plan pays 80% ^                                   |
| <b>Specialty Care Physician Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | \$40 copay, and plan pays 100%                    | Plan pays 80% ^                                   |
| <b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                   |                                                   |
| <b>Surgery Performed in Physician's Office</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Allergy Treatment/Injections and Allergy Serum</b><br>Allergy serum dispensed by the physician in the office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Note:</b> Office copay does not apply if only the allergy serum is provided.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                   |                                                   |
| <b>Chemotherapy and Radiation Therapy</b><br>For services provided in a physician's office                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | Plan pays 100%                                    | Plan pays 80% ^                                   |

| 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>Virtual Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                |                 |
| <b>Dedicated Virtual Providers - MDLIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                 |
| <b>MDLIVE Urgent Virtual Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$30 copay, and plan pays 100% | Not Covered     |
| <b>MDLIVE Primary Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$30 copay, and plan pays 100% | Not Covered     |
| <b>MDLIVE Specialty Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$40 copay, and plan pays 100% | Not Covered     |
| <ul style="list-style-type: none"> <li>Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.</li> <li>For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).</li> <li>Lab services supporting a virtual visit must be obtained through dedicated labs.</li> <li>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.</li> </ul> |                                |                 |
| <b>Virtual Physician Services - Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                |                 |
| <b>Primary Care Physician (PCP) Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$30 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Specialty Care Physician Services/Office Visit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$40 copay, and plan pays 100% | Plan pays 80% ^ |
| <ul style="list-style-type: none"> <li>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</li> <li>Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.</li> </ul>                                                                                                                                              |                                |                 |
| <b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).                                                                                                                                                                                                                                                                                                                                                                                                         |                                |                 |
| <b>Convenience Care Clinic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                |                 |
| <b>Convenience Care Clinic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$30 copay, and plan pays 100% | Plan pays 80% ^ |

| 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>Preventive Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                                         |
| <b>Preventive Care</b><br>Birth through age 2                                                                                                                                                                                                                                                                                                                                                                                                                                                    | PCP: \$30 copay, and plan pays 100%<br>Specialist: \$40 copay, and plan pays 100% | PCP: Plan pays 80% ^<br>Specialist: Plan pays 80% ^                     |
| Ages 3 and older <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                       | PCP: \$30 copay, and plan pays 100%<br>Specialist: \$40 copay, and plan pays 100% | PCP: Plan pays 80% ^<br>Specialist: Plan pays 80% ^                     |
| <b>Immunizations</b><br>Birth through age 4                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Plan pays 100%                                                                    | Plan pays 100%                                                          |
| Ages 5 and older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <b>Mammogram, PAP, PSA Tests and Colorectal Screenings</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefit as other x-ray and lab services, based on place of service.</li> <li>The first mammogram, PAP, PSA test and colonoscopy of the calendar year is considered preventive. Subsequent procedures are considered diagnostic.</li> </ul> | Plan pays 100%                                                                    | Covered same as other x-ray and lab services, based on Place of Service |
| <b>Inpatient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                   |                                                                         |
| <b>Inpatient Hospital Facility Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                                         |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <b>Inpatient Professional Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                                         |
| <b>Outpatient</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                   |                                                                         |
| <b>Outpatient Facility Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <b>Outpatient Professional Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Plan pays 100%                                                                    | Plan pays 80% ^                                                         |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</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>Emergency Services</b>                                                                                                                                                                                                                                    |                                                   |                                                   |
| <b>Emergency Room</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.</li> <li>Per visit copay is waived if admitted.</li> </ul> | \$150 copay, and plan pays 100%                   | \$150 copay, and plan pays 100%                   |
| <b>Urgent Care Facility</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.</li> </ul>                            | \$40 copay, and plan pays 100%                    | \$40 copay, and plan pays 100%                    |
| <b>Ambulance</b>                                                                                                                                                                                                                                             | Plan pays 100%                                    | Plan pays 100%                                    |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.                                                                                                                            |                                                   |                                                   |
| <b>Ambulance - Mental Health and Substance Use Disorder</b>                                                                                                                                                                                                  | Plan pays 100%                                    | Plan pays 100%                                    |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.                                                                                                                            |                                                   |                                                   |
| <b>Inpatient Services at Other Health Care Facilities</b>                                                                                                                                                                                                    |                                                   |                                                   |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> <ul style="list-style-type: none"> <li>Annual Limit: 100 days</li> </ul>                                                                                                      | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <b>Laboratory Services</b>                                                                                                                                                                                                                                   |                                                   |                                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                                                                                     | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Independent Lab</b>                                                                                                                                                                                                                                       | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <b>Outpatient Facility</b>                                                                                                                                                                                                                                   | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <b>Radiology Services</b>                                                                                                                                                                                                                                    |                                                   |                                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                                                                                     | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Outpatient Facility</b>                                                                                                                                                                                                                                   | Plan pays 100%                                    | Plan pays 80% ^                                   |

| 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>Advanced Radiological Imaging (ARI)</b>                                                                                                                                                         | Includes MRI, MRA, CAT Scan, PET Scan, etc.       |                                                   |
| <b>Outpatient Facility</b>                                                                                                                                                                         | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <b>Physician's Services/Office Visit</b>                                                                                                                                                           | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Outpatient Therapy Services</b>                                                                                                                                                                 |                                                   |                                                   |
| <b>Outpatient Therapy Services</b>                                                                                                                                                                 | Plan pays 100%                                    | Covered same as Physician Services - Office Visit |
| Annual Limits:<br><ul style="list-style-type: none"> <li>Occupational Therapy, Physical Therapy and Speech Therapy - Unlimited days</li> </ul>                                                     |                                                   |                                                   |
| <b>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.</b>                                                |                                                   |                                                   |
| <b>Pulmonary Rehabilitation and Cognitive Therapy</b>                                                                                                                                              | \$30 copay, and plan pays 100%                    | Plan pays 80% ^                                   |
| Annual Limits: Unlimited days                                                                                                                                                                      |                                                   |                                                   |
| <b>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.</b>                                                |                                                   |                                                   |
| <b>Chiropractic Services</b>                                                                                                                                                                       | \$30 copay, and plan pays 100%                    | Not covered                                       |
| Annual Limit:<br><ul style="list-style-type: none"> <li>Chiropractic Care - Unlimited days</li> <li>First 26 visit per year without referral, additional visits if medically necessary.</li> </ul> |                                                   |                                                   |
| <b>Cardiac Rehabilitation Services</b>                                                                                                                                                             | \$30 copay, and plan pays 100%                    | Covered same as Physician Services - Office Visit |
| Annual Limit:<br><ul style="list-style-type: none"> <li>Cardiac Rehabilitation - Unlimited days</li> </ul>                                                                                         |                                                   |                                                   |
| <b>Hospice</b>                                                                                                                                                                                     |                                                   |                                                   |
| <b>Inpatient Facilities</b>                                                                                                                                                                        | Plan pays 100%                                    | Plan pays 100%                                    |
| <b>Outpatient Services</b>                                                                                                                                                                         | Plan pays 100%                                    | Plan pays 100%                                    |
| <b>Note: Includes Bereavement counseling provided as part of a hospice program.</b>                                                                                                                |                                                   |                                                   |
| <b>Bereavement Counseling (for services not provided as part of a hospice program)</b>                                                                                                             |                                                   |                                                   |
| Services Provided by a Mental Health Professional                                                                                                                                                  | Covered under Mental Health benefit               | Covered under Mental Health benefit               |

| 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>Medical Pharmaceutical Drugs</b>                                                                                                                                                                                                                                                                                                                                                      |                                      |                                                   |                                                   |
| <b>Cigna Pathwell Specialty® Medical Pharmaceuticals</b>                                                                                                                                                                                                                                                                                                                                 |                                      | Plan pays 100%                                    | Not Covered                                       |
|                                                                                                                                                                                                                                                                                                                                                                                          | <b>Other Medical Pharmaceuticals</b> | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <ul style="list-style-type: none"> <li>Cigna Pathwell Specialty® Medical Pharmaceuticals are only covered when administered by a Cigna Pathwell Specialty® designated provider.</li> <li>This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design.</li> </ul> |                                      |                                                   |                                                   |
| <b>Maternity</b>                                                                                                                                                                                                                                                                                                                                                                         |                                      |                                                   |                                                   |
| <b>Initial Visit to Confirm Pregnancy</b>                                                                                                                                                                                                                                                                                                                                                |                                      | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges</b> (Global Maternity Fee)                                                                                                                                                                                                                                                                          |                                      | Plan pays 100%                                    | Plan pays 80% ^                                   |
| <b>Office Visits in Addition to Global Maternity Fee</b> (Performed by OB/GYN or Specialist)                                                                                                                                                                                                                                                                                             |                                      | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| <b>Delivery - Facility</b> (Inpatient Hospital, Birthing Center)                                                                                                                                                                                                                                                                                                                         |                                      | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |
| <b>Abortion</b>                                                                                                                                                                                                                                                                                                                                                                          |                                      |                                                   |                                                   |
| <b>Abortion Services</b>                                                                                                                                                                                                                                                                                                                                                                 |                                      | Coverage varies based on Place of Service         | Coverage varies based on Place of Service         |
| <b>Note:</b> Non-elective procedures only                                                                                                                                                                                                                                                                                                                                                |                                      |                                                   |                                                   |
| <b>Family Planning</b>                                                                                                                                                                                                                                                                                                                                                                   |                                      |                                                   |                                                   |
| <b>Women's Services</b>                                                                                                                                                                                                                                                                                                                                                                  |                                      | Coverage varies based on Place of Service         | Coverage varies based on Place of Service         |
| Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)                                                                                                                                                                                                                                  |                                      |                                                   |                                                   |
| <b>Men's Services</b>                                                                                                                                                                                                                                                                                                                                                                    |                                      | Coverage varies based on Place of Service         | Coverage varies based on Place of Service         |
| Includes surgical sterilization services, such as vasectomy (excludes reversals)                                                                                                                                                                                                                                                                                                         |                                      |                                                   |                                                   |
| <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.                                                                                                                                                                                        |                                      |                                                   |                                                   |

| 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 Dialysis Services</b>                                                                                                                                                                                           |                                                                 |                                                                 |
| Physician's Services/Office Visit                                                                                                                                                                                             | Covered same as Physician Services - Office Visit               | Covered same as Physician Services - Office Visit               |
| Home Dialysis                                                                                                                                                                                                                 | Covered same as plan's Home Health Care benefit                 | Covered same as plan's Home Health Care benefit                 |
| Outpatient Facility Services                                                                                                                                                                                                  | Covered same as plan's Outpatient Facility Services benefit     | Covered same as plan's Outpatient Facility Services benefit     |
| Outpatient Professional Services                                                                                                                                                                                              | Covered same as plan's Outpatient Professional Services benefit | Covered same as plan's Outpatient Professional Services benefit |
| <b>Other Health Care Facilities/Services</b>                                                                                                                                                                                  |                                                                 |                                                                 |
| <b>Home Health Care</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> <li>16 hour maximum per day</li> </ul> <b>Note:</b> Includes outpatient private duty nursing when approved as medically necessary | Plan pays 100%                                                  | Plan pays 80% ^                                                 |
| <b>Organ Transplants</b>                                                                                                                                                                                                      |                                                                 |                                                                 |
| <b>Inpatient Hospital Facility Services</b>                                                                                                                                                                                   |                                                                 |                                                                 |
| LifeSOURCE Transplant Network® facility                                                                                                                                                                                       | Plan pays 100%                                                  | Not Applicable                                                  |
| Other Facility                                                                                                                                                                                                                | Not Covered                                                     | Not Covered                                                     |
| <b>Inpatient Professional Services</b>                                                                                                                                                                                        |                                                                 |                                                                 |
| LifeSOURCE Transplant Network® facility                                                                                                                                                                                       | Plan pays 100%                                                  | Not Applicable                                                  |
| Other Facility                                                                                                                                                                                                                | Not Covered                                                     | Not Covered                                                     |
| <ul style="list-style-type: none"> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: \$10,000 maximum per Transplant</li> </ul>                                                                        |                                                                 |                                                                 |
| <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                    | Plan pays 100%                                                  | Plan pays 80% ^                                                 |

| 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>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> <li>Intended for medical necessity only</li> </ul> | Plan pays 100%                            | Plan pays 80% ^                           |
| <b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>                                                                                                                                                     | Plan pays 100%                            | Plan pays 80% ^                           |
| <b>Temporomandibular Joint Disorder (TMJ)</b> <ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> </ul>                                                                                                                                                | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| <b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.                                                                                                                                                                    |                                           |                                           |
| <b>Routine Foot Care</b>                                                                                                                                                                                                                                                  | Not Covered                               | Not Covered                               |
| <b>Note:</b> Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.                                                                                                                            |                                           |                                           |
| <b>Orthotics</b> <ul style="list-style-type: none"> <li>Maximum of 1 custom molded shoe inserts per 2 calendar years.</li> </ul>                                                                                                                                          | Plan pays 100%                            | Plan pays 80% ^                           |

| 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>Mental Health and Substance Use Disorder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                |                 |
| <b>Inpatient Mental Health</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Plan pays 100%                 | Plan pays 80% ^ |
| <b>Outpatient Mental Health – Physician’s Office</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$40 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Outpatient Mental Health - MDLIVE Behavioral Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$40 copay, and plan pays 100% | Not Covered     |
| <b>Outpatient Mental Health – All Other Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Plan pays 100%                 | Plan pays 80% ^ |
| <b>Inpatient Substance Use Disorder</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Plan pays 100%                 | Plan pays 80% ^ |
| <b>Outpatient Substance Use Disorder – Physician’s Office</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$40 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Outpatient Substance Use Disorder - MDLIVE Behavioral Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$40 copay, and plan pays 100% | Not Covered     |
| <b>Outpatient Substance Use Disorder – All Other Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Plan pays 100%                 | Plan pays 80% ^ |
| 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 and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.</li> <li>Services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul> |                                |                 |
| <b>Important Note on Mental Health and Substance Use Disorder Coverage:</b> Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled “Mental Health and Substance Use Disorder.”                                                                                                                                                                                                                                      |                                |                 |
| <b>Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                |                 |
| <b>Cigna Total Behavioral Health - Inpatient and Outpatient Management</b> <ul style="list-style-type: none"> <li>Inpatient utilization review and case management</li> <li>Outpatient utilization review and case management</li> <li>Partial Hospitalization</li> <li>Intensive outpatient programs</li> <li>Changing Lives by Integrating Mind and Body Program</li> <li>Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.</li> </ul>                                                                |                                |                 |

## Pharmacy

Benefits not provided by Cigna.

## Additional Information

### Case Management

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

### Cigna Diabetes Prevention Program in collaboration with Omada

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

### Maximum Reimbursable Charge

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

### Out-of-Network Emergency Services Charges

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

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

### Medicare Coordination

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

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
- (b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
- (c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

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## Additional Information

### Multiple Surgical Reduction

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

### One Guide

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

### Premium Personal Health Team

The Premium Personal Health Team is a designated and integrated service delivery approach using a one health advocate model. Core functions include:

- Case Management - Short term and complex
- Inpatient Advocacy
- Pre Admission Outreach
- Post Discharge Outreach
- 24 hour Health Information Line Outreach

Care Facility - St. Louis

### Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

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

- \$500 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

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

In-Network: Coordinated by your physician

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

- \$500 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

### Treatment Decision Support

Treatment decision support for common health conditions. Cigna health advocates provide unbiased information and education on treatment options for common health conditions, including: back pain, coronary artery disease, osteoarthritis of the hip and knee, benign uterine conditions, breast cancer and prostate cancer.

Included

## Additional Information

### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

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

Holistic health support for the following chronic health conditions:

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

## Definitions

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

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

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

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

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

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

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

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

## Exclusions

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

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

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

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## Exclusions

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

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

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not

## Exclusions

limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

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## Exclusions

- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- Pregnancy of a dependent child.

### 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.

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

EHB State: MO

# Discrimination is against the law.

## Medical coverage

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

### Cigna Healthcare:

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

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



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

### Cigna Healthcare

Nondiscrimination Complaint Coordinator  
P.O. Box 188016  
Chattanooga, TN 37422

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

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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