# SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**
**For - Western Union Company**
**Choice Fund Open Access Plus HSA Plan**

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

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

| **Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.** | |
|---|---|
| **Employer Contribution** | Employee - $500<br>Family - $1,000 |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Coinsurance**<br>• Coinsurance values can vary for specific benefits | Your plan pays 80% | Your plan pays 60% |
| **Maximum Reimbursable Charge** | Not Applicable | 150% |
| **Calendar Year Deductible** | Individual: $2,000<br>Family: $4,000 | Individual: $4,000<br>Family: $8,000 |

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- Plan deductible always applies before any copay or coinsurance.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.

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

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Calendar Year Out-of-Pocket Maximum** | Individual: $4,000<br>Individual – In a Family: $7,150<br>Family: $8,000 | Individual: $8,000<br>Individual – In a Family: $16,000<br>Family: $16,000 |
| • The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.<br>• Plan deductible contributes towards your out-of-pocket maximum.<br>• Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.<br>• 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.<br>• This plan includes a combined Medical/Pharmacy out-of-pocket maximum. | | |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Physician Services** | | |
| **Physician Office Visit – Primary Care Physician (PCP)**<br>• All services including Lab & X-ray | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Physician Office Visit – Specialist**<br>• All services including Lab & X-ray | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist) | | |
| **Surgery Performed in Physician's Office - PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Surgery Performed in Physician's Office – Specialist** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Allergy Treatment/Injections Performed in Physician's Office PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Allergy Treatment/Injections Performed in Specialist Office** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Allergy Serum - PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Allergy Serum - Specialist**<br>• Dispensed by the physician in the office | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Preventive Care** | | |
| **Preventive Care** | Your plan pays 100% | PCP: Your plan pays 100%<br>Specialist: Your plan pays 100% |
| • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. | | |
| **Immunizations** | Your plan pays 100% | PCP: Your plan pays 100%<br>Specialist: Your plan pays 100% |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Travel Immunizations** | Plan pays 100% | PCP: After the plan deductible is met, your plan pays 60%<br>Specialist: After the plan deductible is met, your plan pays 60% |
| **Mammogram, PAP, PSA Tests, and Colonoscopy** | Plan pays 100% | After your plan deductible is met, your plan pays 60% |
| • Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. | | |
| **Inpatient** | | |
| **Inpatient Hospital Facility** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Semi-Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br>**Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate | | |
| **Inpatient Hospital Physician's Visit/Consultation** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Outpatient** | | |
| **Outpatient Facility Services**<br>• Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Outpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Short-Term Rehabilitation - PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Short-Term Rehabilitation - Specialist** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| Calendar Year Maximums:<br>• Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 60 days<br>• Chiropractic Care - 20 days<br>• Physical Therapy and Occupational Therapy coverage for autism and developmental delays.<br>• Speech therapy is covered for children who failed to achieve complete speech articulation due to hearing loss, corrective surgery for congenital defects, cerebral palsy, spina bifida, multiple sclerosis, autism, neurological disorders or Down's Syndrome.<br><br>Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. | | |
| **Other Health Care Facilities/Services** | | |
| **Short-Term Rehabilitation – Specialist**<br>• Cardiac Rehabilitation - 36 days | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Home Health Care**<br>(includes outpatient private duty nursing subject to medical necessity)<br>• 120 days maximum per Calendar Year<br>• 16 hour maximum per day | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility**<br>• 120 days maximum per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Durable Medical Equipment**<br>• Unlimited maximum per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.<br>• Includes related supplies | Your plan pays 100% | After the plan deductible is met, your plan pays 60% |
| **External Prosthetic Appliances (EPA)**<br>• Unlimited maximum per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Acupuncture**<br>• Unlimited maximum per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Hearing Exam**<br>• 1 exam per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Routine Foot Disorders** | Not Covered | Not Covered |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Acupuncture Performed in Physician's Office - PCP** | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Acupuncture Performed in Physician's Office - Specialist**<br>• Unlimited maximum per Calendar Year | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Wigs**<br>• Unlimited maximum per Calendar Year<br>• Covered when medical necessity | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Medical Specialty Drugs** | | |
| **Inpatient**<br>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Outpatient Facility Services**<br>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Physician's Office**<br>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |
| **Home**<br>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges. | After the plan deductible is met, your plan pays 80% | After the plan deductible is met, your plan pays 60% |

## Place of Service - your plan pays based on where you receive services

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

| Benefit | Physician's Office | | Independent Lab | | Emergency Room/ Urgent Care Facility | | Outpatient Facility | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Laboratory** | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 80%^ | Plan pays 80%^ | Plan pays 60%^ |
| **Radiology** | Plan pays 80%^ | Plan pays 60%^ | Not Applicable | Not Applicable | Plan pays 80%^ | Plan pays 80%^ | Plan pays 80%^ | Plan pays 60%^ |
| **Advanced Radiology Imaging** | Plan pays 80%^ | Plan pays 60%^ | Not Applicable | Not Applicable | Plan pays 80%^ | Plan pays 80%^ | Plan pays 80%^ | Plan pays 60%^ |

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc...
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

| Benefit | Emergency Room / Urgent Care Facility | | Outpatient Professional Services | | *Ambulance | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Emergency Care** | Plan pays 80% ^ | | Plan pays 80% ^ | | Plan pays 80% ^ | |
| **Urgent Care** | Plan pays 80%^ | Plan pays 80%^ | Plan pays 80%^ | Plan pays 80%^ | Not Applicable* | |
| *Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | | | | | |

| Benefit | Inpatient Hospital and Other Health Care Facilities | | Outpatient Services | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Hospice** | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| **Bereavement Counseling** | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| Note: Services provided as part of Hospice Care Program | | | | |
| Note: Services where plan deductible applies are noted with a caret (^) | | | | |

| Benefit | Initial Visit to Confirm Pregnancy | | Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges) | | Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist) | | Delivery - Facility (Inpatient Hospital, Birthing Center) | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Maternity** | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80%^ | Plan pays 60%^ | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |
| Note: Services where plan deductible applies are noted with a caret (^) | | | | | | | | |

| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
|---|---|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Abortion** (Elective and non-elective procedures) | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| **Family Planning - Men's Services** | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80%^ | Plan pays 60%^ |

| Benefit | Physician's Office | | Inpatient Facility | | Outpatient Facility | | Inpatient Professional Services | | Outpatient Professional Services | |
|---|---|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Family Planning - Women's Services** | Plan pays 100% | Plan pays 60%^ | Plan pays 100% | Plan pays 60%^ | Plan pays 100% | Plan pays 60%^ | Plan pays 100% | Plan pays 60%^ | Plan pays 100% | Plan pays 60%^ |
| Includes surgical services, such as tubal ligation (excludes reversals)<br>Contraceptive devices as ordered or prescribed by a physician. | | | | | | | | | | |
| **Infertility** | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.<br>$5,000 lifetime maximum | | | | | | | | | | |
| Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. | | | | | | | | | | |
| **TMJ, Surgical and Non-Surgical** | Plan pays 80%^ | Plan pays 60%^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.<br>Unlimited maximum per lifetime | | | | | | | | | | |
| Note: Services where plan deductible applies are noted with a caret (**^**) | | | | | | | | | | |

| Benefit | Inpatient Hospital Facility | | | Inpatient Professional Services | | |
|---|---|---|---|---|---|---|
| | Lifesource Facility In-Network | Non-Lifesource Facility In-Network | Out-of-Network | Lifesource Facility In-Network | Non-Lifesource Facility In-Network | Out-of-Network |
| **Organ Transplants** | Plan pays 100% ^ | Plan pays 80% ^ | Not Covered | Plan pays 100% ^ | Plan pays 80% ^ | Not Covered |
| • Travel Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant | | | | | | |
| Note: Services where plan deductible applies are noted with a caret (**^**) | | | | | | |

| Benefit | Inpatient | | Outpatient - Physician's Office | | Outpatient – All Other Services | |
|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Mental Health** | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| **Substance Use Disorder** | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ | Plan pays 80% ^ | Plan pays 60% ^ |
| Note: Services where plan deductible applies are noted with a caret (**^**) | | | | | | |

Notes: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum
- Inpatient includes Residential Treatment
- Outpatient includes Individual, Intensive Outpatient, and Group Therapy and Behavioral Telehealth consultation; also Partial Hospitalization

## Mental Health and Substance Use Disorder Services

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

- Inpatient utilization review and case management

| Pharmacy | In-Network |
|---|---|
| **Cost Share and Supply** | |
| **Cigna Pharmacy Cost Share**<br>• Retail – up to 90-day supply (except Specialty up to 30-day supply)<br>• Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) | **Retail (per 30-day supply):**<br>Generic: You pay 20%<br>Preferred Brand: You pay 20%<br>Non-Preferred Brand: You pay 20%<br><br>**Retail (per 90-day supply):**<br>Generic: You pay 20%<br>Preferred Brand: You pay 20%<br>Non-Preferred Brand: You pay 20%<br><br>**Home Delivery (per 90-day supply):**<br>Generic: You pay 20%<br>Preferred Brand: You pay 20%<br>Non-Preferred Brand: You pay 20% |

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 1 Retail fill.
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.

| Pharmacy | In-Network |
|---|---|
| **Pharmacy Savings Program**<br>• Reduced copays may apply for certain generic and brand medications (drug classes) to treat the following conditions: Asthma, Diabetes mellitus, Hyperlipidemia, Hypertension and Heart Disease. | **Retail** - 30 day supply<br>Generic: You pay $4<br>Preferred Brand: You pay 15%/$40 maximum<br>Non-Preferred Brand: You pay 25%/$55 maximum<br><br>**Retail Home delivery** - 90 day supply<br>Generic: You pay $9<br>Preferred Brand: You pay 15%/$100 maximum<br>Non-Preferred Brand: You pay 25%/$138 maximum |

## Drugs Covered

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

- Coverage includes Self Administered injectables and optional injectable drugs – includes infertility drugs.
- Only a limited range of contraceptive devices and drugs are covered.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered
- Lifestyle drugs covered - limited to sexual dysfunction
- Oral Fertility drugs covered
- Prescription weight loss drugs covered
- Prescription smoking cessation drugs covered

## Pharmacy Program Information

**Pharmacy Clinical Management and Prior Authorization**

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.
- Prior authorization is required on specialty medications but quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

**Pharmacy Cost Management Program**
**Step Therapy:** Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix.

<u>High Blood Pressure (ACEI/ARB)</u>

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.

- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Cholesterol Lowering (STATIN)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Bladder Problems (OAB)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Osteoporosis (BONE)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Sleep Disorders (HYPNOTICS)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Allergy (NASAL STEROIDS)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Depression (SSRI/SNRI)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Skin Conditions (TI)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Mental Health (ATYPICAL PSYCHS)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.

## Pharmacy Program Information

- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Non-Narcotic Pain Relievers (NSAID)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

ADD/ADHD (ADHD)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Asthma (ASTHMA)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- Your plan will provide an initial grace period of 60 days for any drugs impacted by Step Therapy.
- Only your first use of a Non-Preferred Brand drug will be covered. You will receive a notice advising you about your next refill.

**Clinical Outcome Programs:**

- Includes complex psychiatric case management
- Includes narcotic therapy management

## 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.

| | |
|---|---|
| **Comprehensive Oncology Program**<br>• Care Management outreach<br>• Case Management | Included |

| Additional Information | |
|---|---|
| **Health Advisor - A**<br>Support for healthy and at-risk individuals to help them stay healthy<br><br>• Health Assessments<br>• Health and Wellness Coaching<br>• Cigna Well Informed Program<br>• Preference Sensitive Care<br>• Educate and Refer | Included |
| **Healthy Pregnancies/Healthy Babies**<br>• Care Management outreach<br>• Maternity Case Management<br>• Neo-natal Case Management | $150 (1st trimester) / $75 (2nd trimester) - Option 3 |
| **Lifestyle Management Programs**<br>• Healthy Steps to Weight Loss<br>• Quit Today<br>• Strength and Resilience | |
| **Maximum Reimbursable Charge**<br>Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (150%) of a fee schedule 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 is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. | |
| **Multiple Surgical Reduction**<br>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. | |

## Additional Information

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

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

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

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

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

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| **Your Health First - 300**<br>Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:<br><br>• Condition Management<br>• Medication adherence<br>• Risk factor management<br>• Lifestyle issues<br>• Health & Wellness issues<br>• Pre/post-admission<br>• Treatment decision support<br>• Gaps in care | Holistic health support for the following chronic health conditions:<br>• Heart Disease<br>• Coronary Artery Disease<br>• Angina<br>• Congestive Heart Failure<br>• Acute Myocardial Infarction<br>• Peripheral Arterial Disease<br>• Asthma<br>• Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)<br>• Diabetes Type 1<br>• Diabetes Type 2<br>• Metabolic Syndrome/Weight Complications<br>• Osteoarthritis<br>• Low Back Pain<br>• Anxiety<br>• Bipolar Disorder<br>• Depression |
| **Telephone or Video Consultations - Services Provided by MDLIVE** | The following procedures are covered at $38 per visit until plan deductible is met, then subject to coinsurance:<br><br>99441 Telephone Consolation (Duration up to 10 minutes)<br>99442 Telephone Consolation (Duration between 11 and 20 minutes)<br>99443 Telephone Consolation (Duration 21 minutes or more)<br>99444 Video/Online Consolation (any duration) |

## Definitions

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

## Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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 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 Service (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 Service, 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 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 related 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 therapies or devices that are determined by the utilization review Physician to be:
    - 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;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

## Exclusions

  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section 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" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- 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 appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation (except as may otherwise be covered under the plan).
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures.
- 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 nonverbal communications, including but not limited to communication boards, prerecorded 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).

## Exclusions

- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription 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.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are 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.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- 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 the benefit section.
- Massage therapy.
- Telephone and video consultation services provided by Health Care Professionals unless as described under the Additional Information section.

**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 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. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.



EHB State: CO