

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Independence Pet Holdings, Inc.
Choice Fund Open Access Plus HSA Plan
HDHP
Effective - 01/01/2025



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

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

A notice for Missouri residents required by RSMo 376.1199.6: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude, and not pay for, coverage for elective abortions if such coverage is contrary to the enrollee's moral, ethical or religious beliefs.

A notice for Oklahoma residents per 63 Okl. St. § 1-741.3: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

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

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

Employer Contribution

Employee - \$600
Family - \$1,200

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 80%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	200%

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Plan Highlights		In-Network	Out-of-Network
Plan Deductible		Individual - Employee Only: \$2,200 Family Maximum: \$4,400	Individual - Employee Only: \$4,000 Family Maximum: \$8,000
<ul style="list-style-type: none"> Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible. Plan deductible always applies before any benefit copay/deductible or coinsurance. Plan deductible does not apply to in-network preventive services. All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied. This plan includes a combined Medical/Pharmacy plan deductible. 			
Note: Services where plan deductible applies are noted with a caret (^).			
Plan Out-of-Pocket Maximum		Individual - Employee Only: \$3,200 Individual - within a Family: \$3,200 Family Maximum: \$6,400	Individual - Employee Only: \$6,400 Individual - within a Family: \$6,400 Family Maximum: \$12,800
<ul style="list-style-type: none"> Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum. Plan deductible contributes towards your out-of-pocket maximum. All benefit copays/deductibles contribute towards your out-of-pocket maximum. Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum. After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. This plan includes a combined Medical/Pharmacy out-of-pocket maximum. 			
Benefit		In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.			
Physician Services - Office Visits			
Primary Care Physician (PCP) Services/Office Visit		Plan pays 80% ^	Plan pays 60% ^
Specialty Care Physician Services/Office Visit		Plan pays 80% ^	Plan pays 60% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).			
Surgery Performed in Physician's Office		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 80% ^	Not Covered
MDLIVE Primary Care Services	Plan pays 80% ^	Not Covered
MDLIVE Specialty Care Services	Plan pays 80% ^	Not Covered
<ul style="list-style-type: none"> Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care. For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). Lab services supporting a virtual visit must be obtained through dedicated labs. Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies. 		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"> Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). 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. 		
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Convenience Care Clinic		
Convenience Care Clinic	Plan pays 80% ^	Plan pays 60% ^
Preventive Care		
Preventive Care	Plan pays 100%	PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
<ul style="list-style-type: none"> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. Annual Limit: Unlimited 		
Immunizations	Plan pays 100%	PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
<ul style="list-style-type: none"> Coverage includes the associated Preventive Outpatient Professional Services. Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service. 		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 		
Outpatient		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 		
Emergency Services		
Emergency Room		
<ul style="list-style-type: none"> Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. 	Plan pays 80% ^	Plan pays 80% ^
Urgent Care Facility		
<ul style="list-style-type: none"> 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. 	Plan pays 80% ^	Plan pays 80% ^
Ambulance	Plan pays 80% ^	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 80% ^	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities		
<ul style="list-style-type: none"> Annual Limit: 60 days 	Plan pays 80% ^	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^

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Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services		
Outpatient Therapy and Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: <ul style="list-style-type: none"> All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 20 days Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Spinal Manipulation and Subluxation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: <ul style="list-style-type: none"> Spinal Manipulation and Subluxation Services - Unlimited days 		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: <ul style="list-style-type: none"> Cardiac Rehabilitation - 36 days 		
Hospice		
Inpatient Facilities	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit

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Medical Pharmaceutical Drugs			
Cigna Pathwell SpecialtySM Medical Pharmaceuticals	Cigna Pathwell SpecialtySM Network:	Plan pays 80% ^	Plan pays 60% ^
	Other Medical Pharmaceuticals	Plan pays 80% ^	Plan pays 60% ^
Note: 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.			
Maternity			
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 80% ^	Plan pays 60% ^	Plan pays 60% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion			
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures			
Family Planning			
Women's Services	Plan pays 100%	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)			
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)			
Infertility			
Infertility Treatment			
Note: 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.			

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Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Other Health Care Facilities/Services		
Home Health Care <ul style="list-style-type: none"> Annual Limit: Unlimited Note: Includes outpatient private duty nursing when approved as medically necessary	Plan pays 80% ^	Plan pays 60% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit up to the following transplant maximums: Bone Marrow - \$130,000 Heart - \$150,000 Heart/Lung - \$185,000 Kidney - \$80,000 Kidney/Pancreas - \$80,000 Liver - \$230,000 Lung - \$185,000 Pancreas - \$50,000
<ul style="list-style-type: none"> Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, Unlimited maximum per Transplant per Lifetime 		
Condition-Specific Care <ul style="list-style-type: none"> Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify. Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply. Travel Maximum - After the deductible is met, \$600 per procedure 	Plan pays 100% ^	Not Applicable
Durable Medical Equipment <ul style="list-style-type: none"> Annual Limit: Unlimited 	Plan pays 80% ^	Plan pays 60% ^
Breast Feeding Equipment and Supplies <ul style="list-style-type: none"> Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies 	Plan pays 100%	Plan pays 70% ^

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Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
External Prosthetic Appliances (EPA) <ul style="list-style-type: none"> Annual Limit: Unlimited 	Plan pays 80% ^	Plan pays 60% ^
Temporomandibular Joint Disorder (TMJ) <ul style="list-style-type: none"> Unlimited lifetime maximum 	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
Routine Foot Care	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.		
Hearing Aids <ul style="list-style-type: none"> Annual Limit: Unlimited Maximum of 2 devices (one per ear) per 36 months Includes testing and fitting of hearing aid devices at Physician Office Visit cost share Coverage through age 21 	Plan pays 100% ^	Plan pays 70% ^

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 80% ^	Plan pays 60% ^
Outpatient Mental Health – Physician’s Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient Mental Health - MDLIVE Behavioral Services	Plan pays 80% ^	Not Covered
Outpatient Mental Health – All Other Services	Plan pays 80% ^	Plan pays 60% ^
Inpatient Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^
Outpatient Substance Use Disorder – Physician’s Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	Plan pays 80% ^	Not Covered
Outpatient Substance Use Disorder – All Other Services	Plan pays 80% ^	Plan pays 60% ^
Annual Limits: <ul style="list-style-type: none"> Unlimited maximum 		
Notes: <ul style="list-style-type: none"> Inpatient includes Acute Inpatient and Residential Treatment. Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc. Services are paid at 100% after you reach your out-of-pocket maximum. 		
Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled “Mental Health and Substance Use Disorder.”		
Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs		
Cigna Total Behavioral Health - Inpatient and Outpatient Management <ul style="list-style-type: none"> Inpatient utilization review and case management Outpatient utilization review and case management Partial Hospitalization Intensive outpatient programs Changing Lives by Integrating Mind and Body Program Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management. Narcotic Therapy Management inMyndSM program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions. 		

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Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Cigna Pharmacy Cost Share <ul style="list-style-type: none"> Retail – up to 90-day supply (except Specialty up to 30-day supply) Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) 	Retail (per 30-day supply): Generic: You pay 20% ^ Preferred Brand: You pay 20% ^ Non-Preferred Brand: You pay 20% ^ Retail and Home Delivery (per 30-day supply): Specialty: You pay 20% ^ Retail and Home Delivery (per 90-day supply): Generic: You pay 20% ^ Preferred Brand: You pay 20% ^ Non-Preferred Brand: You pay 20% ^	Retail: You pay 40% ^ Your plan pays 60% ^ Home Delivery: Same as Retail Out-of-Network
<ul style="list-style-type: none"> Cigna 90 Now CVS: Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. Walgreens will be considered Out-of-Network for a 90 day supply. Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan. Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered. When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW). Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met. 		
Drugs Covered		
Prescription Drug List: Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com. Some highlights: <ul style="list-style-type: none"> Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs. Contraceptive devices and drugs are covered with federally required products covered at 100%. Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered. Prescription weight loss drugs are covered. 		

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Pharmacy Program Information

Pharmacy Clinical Management: Essential

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

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

Patient Assurance Program

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

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

Additional Information

Case Management

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

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.

Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

\$150 (1st trimester) / \$75 (2nd trimester) - Option 3

Additional Information

Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

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

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

Medicare Coordination

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

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

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

Multiple Surgical Reduction

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

One Guide

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

Additional Information

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

In-Network: Coordinated by your physician

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

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- 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.

- 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.

Well-Being Solution: Core

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

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

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Definitions

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

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

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

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

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

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

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

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

Exclusions

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

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
 - o any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
 - o charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
- deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
- reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts the plan does not cover.
- Charges or payment for healthcare-related services that violate 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.

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Exclusions

- 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 for 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.
 - The subject of review or approval by an Institutional Review Board of an academic health institution in the State of Arizona, except for Routine Patient Services as provided in the "Clinical Trials" section of this plan.
 - In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of cancer in at least one of the following standard medical reference compendia or medical literature: the American Hospital Formulary Service Drug Information, a publication of the American society of health system pharmacists, the National Comprehensive Cancer Network Drugs and Biologics Compendium, Thomson Micromedex Compendium DrugDex, Elsevier Gold Standard's Clinical Pharmacology Compendium, Other Authoritative Compendia as Identified by the Secretary of the United States Department of Health and Human Services.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- Court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under 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 sperm, eggs or embryos is also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.

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Exclusions

- Medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames, contact lenses and associated services (exams and fittings), except the initial set after treatment of keratoconus or following cataract surgery.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- 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.
- Products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.
- 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 and fees associated with health clubs, weight loss programs or 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, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Health and beauty aids, cosmetics and dietary supplements.
- For nutritional or dietary supplements, unless those charges are for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering

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medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

- All nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism as specifically provided in the "Enteral Nutrition" benefit.
- Charges for an off-label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has been approved by the U.S. Food and Drug Administration (U.S. FDA). However, such drugs will be covered if: the drug is recognized as safe and effective for treatment of the specific type of cancer in one of the standard medical reference compendia or in medical literature; and the drug has not been determined by the FDA to be contradicted for the specific type of cancer being treated. Coverage will also be provided for any medical services necessary to administer the drug.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- Massage therapy.

These are only the highlights

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

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