The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $6,350/individual - employee only or $12,700/family maximum (no more than $6,350 per individual - within a family) For out-of-network providers: $19,050/individual - employee only or $38,100/family maximum (no more than $19,050 per individual - within a family) Combined medical/behavioral and pharmacy deductible Amount your employer contributes to your account: Up to $750/individual or $1,250/individual + spouse or child or $1,250/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $6,350/individual - employee only or $12,700/family maximum (no more than $6,350 per individual - within a family) For out-of-network providers: $19,050/individual - employee only or $38,100/family maximum (no more than $19,050 per individual - within a family) Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	50% coinsurance	None
	Specialist visit	No charge/visit	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Not covered	Not covered	Contact your employer for non-Cigna coverage that may be available.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.cigna.com	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	50% coinsurance/office visit 50% coinsurance/all other services	50% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	50% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	50% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	No charge	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	50% penalty for no out-of-network precertification. 16 hour maximum per day
	Rehabilitation services	No charge/visit	50% coinsurance/visit	50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 20 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	No charge/visit	50% coinsurance/visit	50% penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	50% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	No charge	50% coinsurance	50% penalty for no out-of-network precertification.
	Hospice services	No charge/inpatient services No charge/outpatient services	50% coinsurance/inpatient services 50% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (combined with Rehabilitation Services)
- Infertility treatment (Lifetime max $30,000)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Georgia Office of Insurance and Safety Fire Commissioner at (800) 656-2298.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$6,350**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,350
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$6,380

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

- **The plan's overall deductible** **$6,350**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,140
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$5,440

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

- **The plan's overall deductible** **$6,350**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,790
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Cigna Value Plan **Ben Ver:** 32 **Plan ID:** 36774201

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Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

cigna healthcare

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

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

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

U.S. Department of Health and Human Services

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

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

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Epiq

Employee Benefit Plan
Summary Plan Description

Value Plan – Prescription Drug Benefit

Effective June 1, 2025

Prescription drug benefits.

The Plan's prescription drug benefits are administered by Rightway.

Prescription drug covered expenses.

Covered prescription drugs include drugs approved by the Food and Drug Administration (FDA) and that are required to be labeled, “Caution – Federal Law prohibits dispensing without a prescription,” insulin and some diabetic supplies when prescribed by a physician or other authorized licensed health professional and dispensed by a licensed pharmacist. This excludes “over-the-counter” medications unless coverage is required by the Affordable Care Act (ACA).

Some FDA-approved drugs may not be covered by the plan if they have over-the-counter (OTC) equivalents or provide low-value as compared to other drugs available on the plan’s formulary. The formulary can be found at www.rightwayhealthcare.com/rightwayrx-more-information and is updated from time-to-time. The Epiq Employee Benefit Plan has elected the Performance formulary.

Prescription drug services, supplies, and medications not covered under the Plan include:

+ Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group)
+ Drugs available without a prescription
+ Drugs labeled “Caution: Limited by federal law to investigational use”
+ Any drug being used for cosmetic purposes, including those for hair growth
+ Medical devices or appliances
+ Prescription drugs not covered by a current prescription order
+ Drugs not listed on the Plan’s Formulary
+ Any compounded drugs that contain products excluded by the Plan
+ Drugs of unproven clinical efficacy and/or value
+ Drugs that have less expensive, but clinically equivalent alternatives
+ Products for nutritional support, unless required for coverage by the Affordable Care Act
+ Products recently approved by the FDA may not be covered upon release to the market
+ Over the counter Non-Sedating Antihistamines (NSAs)
+ Over the counter Nasal Corticosteroids
+ Coverage may be changed and/or the amount you pay may vary based on the condition being treated

Pharmacy network.

Your prescription drug coverage has retail pharmacy, specialty pharmacy, and mail order components. Prescriptions must be obtained through a Rightway contracted in-network pharmacy. You will be responsible for 100% of the drug costs if prescriptions are obtained at out-of-network pharmacies. Talk with one of our Rightway Pharmacy Guides to determine which pharmacies are in-network by calling 833-742-0298.

Specialty prescriptions must be obtained through Walgreens Specialty Pharmacy. In certain instances, you may be required to use a different specialty pharmacy for limited distribution drugs (LDD) that are available only through select specialty pharmacies.

If you choose to obtain your specialty medication with an out-of-network pharmacy, you will be responsible for 100% of the drug costs.

If you have any questions regarding your specialty medication, please contact one of our Rightway Pharmacy Guides by calling 833-742-0298 or by email at specialty@rightwayhealthcare.com

You can easily obtain covered maintenance medications through Rightway's preferred mail pharmacies. Mail service typically includes medications used to treat chronic conditions and are written for up to a 90-day supply, plus refills. Prescriptions that you need to use right away should always be taken to your local in-network retail pharmacy.

The amount you will pay for prescription drug coverage.

Benefits are provided for the payment of the prescription charge, less the amount you pay, according to your benefit design, for each prescription order or refill. You will NEVER pay more than the cost of the drug. The amount you pay for each prescription order or refill will be determined based on the applicable tier of the drug, and the day supply of the drug. Refills of mail order prescriptions are allowed after 75% of the previous prescription has been used (e.g., 23 days in a 30-day supply). For specialty medications and medications filled at retail, refills are allowed after 80% of the prescription has been used. (e.g., 24 days in a 30-day supply)

Drugs are classified in tiers generally by their cost to the plan, with Preferred Generics (Tier 1) drugs having the lowest cost to the plan and Specialty products (Tier 4) having the highest cost to the plan. To determine the Tier in which a drug is classified by your plan, check the formulary at www.rightwayhealthcare.com/rightwayrx-more-information. The Tier classifications are updated periodically.

For Specialty medications, if the drug has copay assistance available, the amount you pay for select specialty medications may be set to the maximum of the current benefit design, $0 or the amount determined by the manufacturer-funded copay assistance program. Once copay assistance is exhausted, the amount you pay will be no more than your benefit design. Dollars used from copay assistance programs will not be considered member out-of-pocket costs and will not count toward your deductible and/or out-of-pocket maximums. Your monthly contribution includes the cost of access to copay assistance services.

The amount you will pay for prescription drug coverage, continued.

Health Plan Deductible	Deductible Type	Individual	Family
Your health plan has a combined medical and Rx deductible.	Embedded	In-Network: $6,350 Out-of-Network: $19,050	In-Network: $12,700 Out-of-Network: $38,100

Non-maintenance prescription drugs.	The amount you pay at an in-network retail pharmacy.	The amount you pay at an out-of-network pharmacy.
Tier 1 drugs (Typically Generic)	No charge after deductible is met	100%
Tier 2 drugs (Typically Preferred Brand)	No charge after deductible is met	100%
Tier 3 drugs (Typically Non-preferred Brand & Generic)	No charge after deductible is met	100%
Max day supply	Up to 90 days	n/a

Maintenance prescription drugs.	The amount you pay at an in-network retail pharmacy.	The amount you pay at an out-of-network pharmacy.
Tier 1 drugs (Typically Generic)	No charge after deductible is met	100%
Tier 2 drugs (Typically Preferred Brand)	No charge after deductible is met	100%
Tier 3 drugs (Typically Non-preferred Brand & Generic)	No charge after deductible is met	100%
Max day supply	Up to 90 days	n/a

Maintenance prescription drugs.	The amount you pay at an in-network mail order pharmacy.	The amount you pay at an out-of-network pharmacy.
Tier 1 drugs (Typically Generic)	No charge after deductible is met	100%
Tier 2 drugs (Typically Preferred Brand)	No charge after deductible is met	100%
Tier 3 drugs (Typically Non-preferred Brand & Generic)	No charge after deductible is met	100%
Max day supply	Up to 90 days	n/a

Specialty prescription drugs.	Walgreens Specialty Pharmacy	The amount you pay at an out-of-network pharmacy.
Tier 4 drugs (Specialty medications)	No charge after deductible is met	100%
Max day supply	Up to 30 days	n/a

The amount you will pay for prescription drug coverage, continued.

Out-of-Pocket Maximum	Out-of-Pocket Type	Individual	Family
Your out-of-pocket maximum is the maximum amount you will pay in any plan year. This means any copay or coinsurance paid by you will apply to your out-of-pocket maximum. Your out-of-pocket maximum is integrated with your medical plan.	Your out-of-pocket maximum is embedded. This means that all eligible in-network individual health care expenses will be covered at 100% once the individual maximum out-of-pocket limit has been satisfied.	In-Network: $6,350 Out-of-Network: $19,050	In-Network: $12,700 Out-of-Network: $38,100

If you paid full price for your medication at the pharmacy and need to get reimbursed via your pharmacy benefit, message us in the Rightway app and we will facilitate a direct member reimbursement. After initiating a chat, you can upload a photo of the pharmacy printout. This printout (usually attached to the prescription bag) contains information about the pharmacy and medication, including the cost of the medication.

Generic and brand-name medications.

Prescription drugs are dispensed under three names: the biosimilar name, generic name, and the brand name. Biosimilar drugs are alternatives to a subset of brand drugs and are almost an identical copy. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, biosimilar, generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

If you choose a brand-name drug, when a generic or biosimilar is available, you may have to pay the copayment for the drug based on the tier for the drug you are choosing plus the difference in cost between the brand drug and the generic or biosimilar drug. This cost difference will not apply to your deductible or out-of-pocket maximums and will continue to be charged after the out-of-pocket maximum has been met.

Maintenance drugs.

Maintenance drugs are certain drugs taken on an ongoing basis, such as those used to treat high blood pressure or high cholesterol. Maintenance drugs are available as a 90-day supply at a network retail pharmacy or as a 90-day supply at a network mail order pharmacy.

Specialty medications.

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are only available through the approved Rightway specialty pharmacy network. The pharmacy network is subject to change. Not all specialty drugs are covered by the pharmacy benefit; some specialty drugs may be covered under the medical benefit.

Specialty medications are either covered by the pharmacy benefit as specified on the formulary or excluded. The Epiq Specialty Program, administered by Rightway, assists Epiq members with your out-of-pocket costs for an excluded brand specialty drug. When you enroll in the program, Rightway will assist in helping you identify and obtain funding from manufacturers, foundations, and/or other third parties that may result in minimal out-of-pocket expenses for you.

Specialty Preferred Generic, Preferred Brand and Non-Preferred Brand Drugs are drugs on the Rightway Specialty Drug list that are covered under the pharmacy benefit at the designated tier. They are required to be filled at a Rightway Specialty Network pharmacy.

Excluded Specialty Brand Drugs are Specialty Products listed on the Epiq Specialty Program Drug list that are excluded from coverage under the pharmacy benefit. Your enrollment in the Epiq Specialty Program will allow Rightway to identify potential alternative funding programs for these select specialty drugs. If you do not enroll in the Specialty Program, you will pay 100% of drug costs for Specialty Program drugs.

Discounts, coupons, or other similar financial assistance from alternative funding sources will not count against your annual deductible or maximum out-of-pocket requirement. Only the amount that you pay will be credited as a true out-of-pocket payment that will apply to your annual deductible and maximum out-of-pocket requirement.

The Epiq Specialty Program is not available in Georgia, Kentucky, Louisiana, North Carolina, Oklahoma, or Virginia. This list of excluded states is subject to change. Please contact Rightway at 833-742-0298 for further information.

Diabetic products.

Select insulin products, needles, syringes, test strips, Omnipod, V-Go, and formulary glucose meters are the only diabetic supplies available as prescription drug benefits under the plan and you will be responsible for your cost share based on your benefit design. All diabetic supplies, including glucose monitors, have a separate copayment for each prescription order or refill.

Compound medications.

Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or clinically appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. In addition, it must not include drugs excluded from plan coverage.

Preventive drugs covered under the Affordable Care Act (ACA).

The following products will be covered at 100% without a copay if you have a prescription as a preventive service. If a generic product is available, only the generic will be covered at 100% without a copay. These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan.

- OTC aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Select generic Statin preventive medication for adults 40 to 75 at high risk
- Select, generic FDA-approved contraceptives for women of childbearing age
- Generic fluoride supplements for children from birth to 16 years
- OTC folic acid supplements for women aged 55 or younger
- Select Iron supplements for children 6 to 12 months at risk for anemia.
- Select smoking cessation products for adults aged 18 and older
- Select breast cancer preventive drugs for adults aged 35 years and older at increased risk for breast cancer
- Select bowel preparations for colonoscopy procedures for adults aged 45 to 74 years
- Pre-Exposure Prophylaxis (PrEP) – generic Truvada
- Vaccinations
    - Hepatitis A and B
    - Varicella
    - Zoster (Shingles)
    - Diphtheria, Tetanus, Pertussis
    - Meningococcal
    - Influenza
    - Pneumococcal (Pneumonia)
    - Human Papillomavirus (HPV)
    - Poliovirus
    - Measles, Mumps, Rubella
    - COVID

Drug coverage guidelines — quality and utilization management.

To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy. More information can be found in the online formulary under the specific medication. You may also call the Customer Service Department number at 833-742-0298.

1. **Prior Authorization.** The Plan requires a review to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, Rightway will work with your prescriber to complete the prior authorization review. Either you or the pharmacy can ask your doctor to call 1-888-665-1885 to initiate the prior authorization or appeal process. You can also contact Rightway via fax at 1-888-498-1038. Prior Authorization Forms can be found at rightwayhealthcare.com/rightwayrx-more-information. Once your prior authorization is reviewed, a clinician may contact your doctor to discuss your case and potential medication alternatives. Your doctor may change your prescription, when medically appropriate, to a different brand name or generic medication.
2. **Quantity Restrictions.** For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current scientific literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design.
3. **Step Therapy.** In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.