



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

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | For <a href="#">in-network providers</a> : \$2,000/individual or \$4,000/family<br>For <a href="#">out-of-network providers</a> : \$4,500/individual or \$13,500/family   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, emergency room visits, <a href="#">urgent care</a> facility visits.   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">in-network providers</a> : \$6,000/individual or \$12,000/family<br>For <a href="#">out-of-network providers</a> : \$13,500/individual or \$40,500/family<br>Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a> | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

| Important Questions  | Answers   | Why This Matters:  |
|--|---|--|
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-Cigna24 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |



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

| Common Medical Event  | Services You May Need                                    | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | In-Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness         | \$30 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a>                    | None  |
|   | <a href="#">Specialist</a> visit                         | \$60 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a>                    | None  |
|   | <a href="#">Preventive care/ screening/ immunization</a> | No charge<br><a href="#">Deductible</a> does not apply                         | 40% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)      | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | None  |
|   | Imaging (CT/PET scans, MRIs)                             | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | 50% penalty for no out-of-network precertification.   |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> | 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  |   |
|   | Non-preferred brand drugs (Tier 3)                       | Not covered  | Not covered  |   |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)   |  |
| is available at <a href="http://www.cigna.com">www.cigna.com</a>          | <a href="#">Specialty drugs</a> (Tier 4)         | Not covered   | Not covered  |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$200 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply   | \$200 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                      | Per visit <a href="#">copay</a> is waived if admitted. Out-of-network services are paid at the in-network cost share.  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> . Services for MH/SA diagnoses will be payable according to <a href="#">Emergency room care</a> benefits. |
|   | <a href="#">Urgent care</a>                      | \$75 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply  | \$75 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                       | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copay</a> /office visit**<br>20% <a href="#">coinsurance</a> /all other services<br>** <a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a> /office visit<br>40% <a href="#">coinsurance</a> /all other services | 50% penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.   |
|   | Inpatient services                               | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.   |
| If you are pregnant   | Office visits                                    | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.  |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  |  |

| Common Medical Event   | Services You May Need                   | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |  |
|  | Childbirth/delivery facility services   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                     |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>        | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.<br>16 hour maximum per day   |
|  | <a href="#">Rehabilitation services</a> | \$30 <a href="#">copay</a> /PCP visit**<br>\$60 <a href="#">copay</a> / <a href="#">Specialist</a> visit**<br>** <a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a> /PCP visit<br>40% <a href="#">coinsurance</a> / <a href="#">Specialist</a> visit | 50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 20 days for <a href="#">Rehabilitation</a> and Chiropractic care services; 36 days for Cardiac rehab services.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
|  | <a href="#">Habilitation services</a>   | \$30 <a href="#">copay</a> /PCP visit**<br>\$60 <a href="#">copay</a> / <a href="#">Specialist</a> visit**<br>** <a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a> /PCP visit<br>40% <a href="#">coinsurance</a> / <a href="#">Specialist</a> visit | 50% penalty for failure to precertify out-of-network speech therapy services. Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | 50% penalty for no out-of-network precertification.<br>Coverage is limited to 60 days annual max. |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | 50% penalty for no out-of-network precertification.   |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a> /inpatient services<br>20% <a href="#">coinsurance</a> /outpatient services | 40% <a href="#">coinsurance</a> /inpatient services<br>40% <a href="#">coinsurance</a> /outpatient services | 50% penalty for failure to precertify out-of-network inpatient <a href="#">hospice services</a> . |
| 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Children)</li> </ul>                   | <ul style="list-style-type: none"> <li>Eye care (Children)</li> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li><a href="#">Prescription drugs</a></li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |
|--|---|
| <ul style="list-style-type: none"> <li>Chiropractic care (combined with <a href="#">Rehabilitation Services</a>)</li> </ul>                  | <ul style="list-style-type: none"> <li>Infertility treatment (Lifetime max \$30,000)</li> </ul> |

### Your Rights to Continue Coverage:

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

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information 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](http://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, kwijigo 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](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$30           |
| <a href="#">Coinsurance</a>       | \$2,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$30           |
| <b>The total Peg would pay is</b> | <b>\$4,160</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$120          |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$4,300        |
| <b>The total Joe would pay is</b> | <b>\$4,820</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$980          |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$10           |
| <b>The total Mia would pay is</b> | <b>\$1,490</b> |

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

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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.



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

### Cigna Healthcare

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

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

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

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

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

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## Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Epiq

# Employee Benefit Plan Summary Plan Description



Copay 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](http://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 includes a retail pharmacy, specialty pharmacy, and mail-order component. Prescriptions must be obtained through a Rightway-contracted in-network pharmacy. If prescriptions are obtained at out-of-network pharmacies, you will be responsible for 100% of the drug costs. Call 833-742-0298 to talk with one of our Rightway Pharmacy Guides to determine which pharmacies are in-network.

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](mailto: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](http://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 plan has a combined medical and Rx deductible, but the deductible does not need to be met in order for the plan to pay the below benefits. | Embedded        | In-Network: \$2,000<br><br>Out-of-Network: \$4,500 | In-Network: \$4,000<br><br>Out-of-Network: \$13,500 |

| Non-maintenance prescription drugs.                              | The amount you pay at an in-network <u>retail</u> pharmacy.                    | The amount you pay at an out-of-network pharmacy. |
|--|--|---|
| <b>Tier 1 drugs</b><br>(Typically Generic)                       | 20% coinsurance with a minimum of \$15 and a maximum of \$50 per prescription  | 100%  |
| <b>Tier 2 drugs</b><br>(Typically Preferred Brand)               | 20% coinsurance with a minimum of \$35 and a maximum of \$100 per prescription | 100%  |
| <b>Tier 3 drugs</b><br>(Typically Non-preferred Brand & Generic) | 20% coinsurance with a minimum of \$75 and a maximum of \$200 per prescription | 100%  |
| Max day supply   | Up to 90 days  | n/a   |

| Maintenance prescription drugs.                                  | The amount you pay at an in-network <u>retail</u> pharmacy.                     | The amount you pay at an out-of-network pharmacy. |
|--|---|---|
| <b>Tier 1 drugs</b><br>(Typically Generic)                       | 20% coinsurance with a minimum of \$15 and a maximum of \$100 per prescription  | 100%  |
| <b>Tier 2 drugs</b><br>(Typically Preferred Brand)               | 20% coinsurance with a minimum of \$75 and a maximum of \$200 per prescription  | 100%  |
| <b>Tier 3 drugs</b><br>(Typically Non-preferred Brand & Generic) | 20% coinsurance with a minimum of \$125 and a maximum of \$400 per prescription | 100%  |
| Max day supply   | Up to 90 days   | n/a   |

| Maintenance prescription drugs.                                  | The amount you pay at an in-network <u>mail order</u> pharmacy.                 | The amount you pay at an out-of-network pharmacy. |
|--|---|---|
| <b>Tier 1 drugs</b><br>(Typically Generic)                       | 20% coinsurance with a minimum of \$15 and a maximum of \$100 per prescription  | 100%  |
| <b>Tier 2 drugs</b><br>(Typically Preferred Brand)               | 20% coinsurance with a minimum of \$75 and a maximum of \$200 per prescription  | 100%  |
| <b>Tier 3 drugs</b><br>(Typically Non-preferred Brand & Generic) | 20% coinsurance with a minimum of \$125 and a maximum of \$400 per prescription | 100%  |
| Max day supply   | Up to 90 days   | n/a   |

| Specialty prescription drugs.           | Walgreens <u>Specialty</u> Pharmacy  | The amount you pay at an out-of-network pharmacy. |
|---|--|---|
| Tier 4 drugs<br>(Specialty medications) | 20% coinsurance with a minimum of \$05 and a maximum of \$200 per prescription<br>(Mail order up to a 30-day supply) | 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: \$6,000<br><br>Out-of-Network: \$13,500 | In-Network: \$12,000<br><br>Out-of-Network: \$40,500 |

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.

## Biosimilar Medications

Biosimilar medications are specialty/biologic medications highly similar to another already approved specialty/biologic medicine ("reference medicine"). Example: Reference medication called "Humira" and biosimilars of this medication, including "Yusimry", "adalimumab-adaz" and others.

Your plan administrator may opt to cover only biosimilar medications as part of the specialty medications and exclude from coverage the "reference" brand drug. If the brand drug is excluded, you may not obtain coverage for that medication and



must use the “biosimilar” drug. In some instances, the biosimilar medications may be obtained at a much lower cost than your Specialty drug copay.

## 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
  - o Hepatitis A and B
  - o Varicella
  - o Zoster (Shingles)
  - o Diphtheria, Tetanus, Pertussis
  - o Meningococcal
  - o Influenza
  - o Pneumococcal (Pneumonia)
  - o Human Papillomavirus (HPV)
  - o Poliovirus
  - o Measles, Mumps, Rubella
  - o 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](https://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.