

## BENEFIT SUMMARY



**Cigna Health and Life Insurance Co.**  
**For - City of Lebanon, TN**  
**LocalPlus Plan**  
**LocalPlus**  
**Effective - 04/01/2023**

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

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

| Plan Highlights   | In-Network   | Out-of-Network                         |
|---|--|--|
| <b>Lifetime Maximum</b>   | Unlimited  | Unlimited                              |
| <b>Plan Year Accumulation</b>   | Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. |  |
| <b>Plan Coinsurance</b>   | Plan pays 80%  | Plan pays 60%                          |
| <b>Maximum Reimbursable Charge</b>  | Not Applicable   | 110%                                   |
| <b>Plan Deductible</b>  | Individual: \$2,000<br>Family: \$4,000   | Individual: \$4,000<br>Family: \$8,000 |
| <ul style="list-style-type: none"> <li>• 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.</li> <li>• Benefit copays/deductibles always apply before plan deductible and coinsurance.</li> <li>• Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</li> </ul> |  |  |
| <b>Note:</b> Services where plan deductible applies are noted with a caret (^).   |  |  |

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| Plan Highlights  | In-Network                             | Out-of-Network                          |
|--|--|---|
| <b>Plan Out-of-Pocket Maximum</b>  | Individual: \$3,000<br>Family: \$6,000 | Individual: \$5,000<br>Family: \$10,000 |
| <ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</li> <li>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.</li> <li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul> |  |   |

| Benefit   | In-Network | Out-of-Network |
|---|------------|----------------|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b> |            |                |

| <b>Physician Services - Office Visits</b>                 |                                |                 |
|---|--------------------------------|-----------------|
| <b>Primary Care Physician (PCP) Services/Office Visit</b> | \$40 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Specialty Care Physician Services/Office Visit</b>     | \$60 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Surgery Performed in Physician's Office</b>            | Plan pays 80% ^                | Plan pays 60% ^ |

| <b>Virtual Care</b>                         |                                |             |
|---|--------------------------------|-------------|
| <b>Dedicated Virtual Providers - MDLIVE</b> |                                |             |
| <b>MDLIVE Urgent Virtual Care Services</b>  | \$40 copay, and plan pays 100% | Not Covered |
| <b>MDLIVE Primary Care Services</b>         | \$40 copay, and plan pays 100% | Not Covered |
| <b>MDLIVE Specialty Care Services</b>       | \$60 copay, and plan pays 100% | Not Covered |

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- 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.

| <b>Virtual Physician Services - Office Visits</b>         |                                |                 |
|---|--------------------------------|-----------------|
| <b>Primary Care Physician (PCP) Services/Office Visit</b> | \$40 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Specialty Care Physician Services/Office Visit</b>     | \$60 copay, and plan pays 100% | Plan pays 80% ^ |

- 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.

| Benefit   | In-Network                      | Out-of-Network                                    |
|---|---------------------------------|---|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>   |                                 |   |
| <b>Preventive Care</b>  |                                 |   |
| <b>Preventive Care Office Visit</b>   | Plan pays 100%                  | Plan pays 80% ^                                   |
| <b>Preventive Services</b>  | Plan pays 100%                  | Plan pays 80% ^                                   |
| <ul style="list-style-type: none"> <li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul> |                                 |   |
| <b>Immunizations</b>  | Plan pays 100%                  | Plan pays 80% ^                                   |
| <b>Inpatient</b>  |                                 |   |
| <b>Inpatient Hospital Facility Services</b>   | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <b>Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs</b>  |                                 |   |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>  | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <b>Inpatient Professional Services</b>  | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>  |                                 |   |
| <b>Outpatient</b>   |                                 |   |
| <b>Outpatient Facility Services</b>   | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <b>Outpatient Professional Services</b>   | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>  |                                 |   |
| <b>Emergency Services</b>   |                                 |   |
| <b>Emergency Room</b>   | \$500 copay, and plan pays 100% |   |
| <ul style="list-style-type: none"> <li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li> <li>Per visit copay is waived if admitted.</li> </ul>  |                                 |   |
| <b>Urgent Care Facility</b>   | \$100 copay, and plan pays 100% | Plan pays 80% ^                                   |
| <ul style="list-style-type: none"> <li>Includes Physician Charges, Lab and Radiology</li> </ul>   |                                 |   |
| <b>Ambulance</b>  | Plan pays 80% ^                 |   |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.   |                                 |   |
| <b>Inpatient Services at Other Health Care Facilities</b>   |                                 |   |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b>  | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <ul style="list-style-type: none"> <li>Annual Limit: 100 days</li> </ul>  |                                 |   |
| <b>Laboratory Services</b>  |                                 |   |
| <b>Physician's Services/Office Visit</b>  | Plan pays 100% ^                | Covered same as Physician Services - Office Visit |
| <b>Independent Lab</b>  | Plan pays 80% ^                 | Plan pays 60% ^                                   |
| <b>Outpatient Facility</b>  | Plan pays 80% ^                 | Plan pays 60% ^                                   |

| Benefit  | In-Network  | Out-of-Network                                    |
|--|---|---|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>  |   |   |
| <b>Radiology Services</b>  |   |   |
| 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% ^                                   |
| <b>Advanced Radiological Imaging (ARI)</b>   |   |   |
| Includes MRI, MRA, CAT Scan, PET Scan, etc.  |   |   |
| Outpatient Facility  | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| Physician's Services/Office Visit  | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| <b>Outpatient Therapy Services</b>   |   |   |
| Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy  | \$40 copay, and plan pays 100%                    | Plan pays 80% ^                                   |
| Annual Limits:   |   |   |
| <ul style="list-style-type: none"> <li>All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul> |   |   |
| <b>Note:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.   |   |   |
| Chiropractic Care  | \$40 copay, and plan pays 100%                    | Plan pays 60% ^                                   |
| Annual Limit:  |   |   |
| <ul style="list-style-type: none"> <li>Chiropractic Care – 20 visits</li> </ul>  |   |   |
| <b>Hospice</b>   |   |   |
| Inpatient Facilities   | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| Outpatient Services  | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| <b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.  |   |   |
| <b>Medical Specialty Drugs</b>   |   |   |
| Outpatient Facility  | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| Physician's Office   | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| Home   | Plan pays 80% ^                                   | Plan pays 60% ^                                   |
| <b>Note:</b> This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.   |   |   |

| Benefit  | In-Network                                | Out-of-Network                            |
|--|---|---|
| <b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>  |   |   |
| <b>Family Planning</b>   |   |   |
| <b>Women's Services</b>  | Plan pays 100%                            | Coverage varies based on Place of Service |
| Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)  |   |   |
| <b>Men's Services</b>  | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| Includes surgical sterilization services, such as vasectomy (excludes reversals)   |   |   |
| <b>Abortion</b>  |   |   |
| <b>Abortion Services</b>   | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| <b>Note:</b> Non-elective procedures only  |   |   |
| <b>Infertility</b>   |   |   |
| <b>Infertility Treatment</b>   |   |   |
| <b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.  |   |   |
| <b>Other Health Care Facilities/Services</b>   |   |   |
| <b>Home Health Care</b>  | Plan pays 80% ^                           | Plan pays 60% ^                           |
| <ul style="list-style-type: none"> <li>Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>  |   |   |
| <b>Organ Transplants</b>   | Covered same as Inpatient benefit         | Not covered                               |
| <ul style="list-style-type: none"> <li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: Unlimited maximum per Transplant per Lifetime</li> <li>Bone marrow transplants for the treatment of cancer are covered out-of-network</li> </ul> |   |   |
| <b>Durable Medical Equipment and External Prosthetic Appliances</b>  | Plan pays 80% ^                           | Plan pays 60% ^                           |
| <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>  |   |   |
| <b>Breast Feeding Equipment and Supplies</b>   | Plan pays 100%                            | Plan pays 60% ^                           |
| <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>  |   |   |
| <b>Temporomandibular Joint Disorder (TMJ)</b>  | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| <ul style="list-style-type: none"> <li>Annual Limit: Unlimited for Surgical and Non-Surgical treatment</li> </ul>  |   |   |
| <b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.   |   |   |
| <b>Hearing Aids</b>  | Plan pays 100%                            | Plan pays 100%                            |
| <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> <li>Maximum of 2 devices (one per ear) per 3 years</li> <li>Includes testing and fitting of hearing aid devices</li> <li>Coverage through age 17</li> </ul>  |   |   |

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

## Mental Health and Substance Use Disorder

|   |                                |                 |
|---|--------------------------------|-----------------|
| <b>Inpatient Mental Health</b>                                | Plan pays 80% ^                | Plan pays 60% ^ |
| <b>Outpatient Mental Health – Physician’s Office</b>          | \$60 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Outpatient Mental Health – All Other Services</b>          | Plan pays 80% ^                | Plan pays 80% ^ |
| <b>Inpatient Substance Use Disorder</b>                       | Plan pays 80% ^                | Plan pays 60% ^ |
| <b>Outpatient Substance Use Disorder – Physician’s Office</b> | \$60 copay, and plan pays 100% | Plan pays 80% ^ |
| <b>Outpatient Substance Use Disorder – All Other Services</b> | Plan pays 80% ^                | Plan pays 80% ^ |

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - 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.

## Pharmacy

## In-Network

### Cost Share and Supply

#### Pharmacy Cost Share

- 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)
- Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.

#### Retail (per 30-day supply):

Generic: You pay \$20  
Preferred Brand: You pay \$45  
Non-Preferred Brand: You pay \$75

#### Retail and Home Delivery (per 90-day supply):

Generic: You pay \$60  
Preferred Brand: You pay \$135  
Non-Preferred Brand: You pay \$225

- 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.
- This plan will not cover out-of-network pharmacy benefits.
- 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 you request a brand drug, you pay 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) (MAC B).
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

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## Drugs Covered

### Prescription Drug List:

Your Cigna Advantage 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:

- Coverage includes Self Administered 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.

## 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 only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

## Additional Information

### 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.

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

### Out-of-Network Emergency Services Charges

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

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

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan 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, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, 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.**

### 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.

### Complete Care Management

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, the lesser of 40% of covered expenses or a \$750 penalty will be applied.

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



## 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 (This Is Not All Inclusive; check your plan documents for a complete list)

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any workers' compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services

### 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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# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

- 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 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](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO 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](mailto: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)  
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<http://www.hhs.gov/ocr/office/file/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 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, 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 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, 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 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, 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, 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 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 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, 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 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 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せん。現在のCigna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 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-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 می‌شود. برای مشتریان فعلی Cigna، 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 ناشنوايان: شماره 711 را شماره‌گیری کنید).