BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - FIRSTCALL MECHANICAL GROUP, LLC
HRA OAP Plan
HRA OAP
Effective - 01/01/2026

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

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

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the calendar year.

Employer Contribution • Copays for medical expenses are not reimbursed from the account. • Copays for pharmacy expenses are not reimbursed from the account. • The Individual amount is the maximum the account will pay for any one person in the family. • Out-of-Network expenses are not reimbursed from the account.	Individual - $1,000 Family - $2,000

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 80%
Maximum Reimbursable Charge	Not Applicable	110%

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Plan Highlights	In-Network	Out-of-Network
Plan Deductible	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- 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.

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

Plan Out-of-Pocket Maximum	Individual: $6,850 Family: $13,700	Individual: $7,500 Family: $15,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$35 copay, and plan pays 100% ^	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Plan pays 80% ^
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	$35 copay, and plan pays 100% ^	Not Covered
MDLIVE Primary Care Services	$35 copay, and plan pays 100% ^	Not Covered
MDLIVE Specialty Care Services	$45 copay, and plan pays 100% ^	Not Covered

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$35 copay, and plan pays 100% ^	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	$45 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.		
Convenience Care Clinic		
Convenience Care Clinic	$35 copay, and plan pays 100% ^	Plan pays 80% ^
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 80% ^
Preventive Services	Plan pays 100%	Plan pays 80% ^
• Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Immunizations	Plan pays 100%	Plan pays 80% ^
Inpatient		
Inpatient Hospital Facility Services	$250 per admission deductible, and plan pays 100%	Plan pays 80% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^	Plan pays 80% ^
Inpatient Professional Services	Plan pays 100% ^	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services Non-surgical treatment procedures are not subject to the facility per visit deductible.	$250 per admission deductible, and plan pays 100%	Plan pays 80% ^
Outpatient Professional Services	Plan pays 100% ^	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI) • Per visit copay is waived if admitted.	$250 copay, and plan pays 100% ^	
Urgent Care Facility • Includes Physician Charges, Lab and Radiology	$45 copay, and plan pays 100% ^	Plan pays 80% ^

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Ambulance	Plan pays 100% ^	
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100% ^	
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 100% ^	Plan pays 80% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100% ^	Plan pays 80% ^
Outpatient Facility	Plan pays 100% ^	Plan pays 80% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100% ^	Plan pays 80% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	$75 scan per day copay, and plan pays 100%	Plan pays 80% ^
Physician's Services/Office Visit	$75 scan per day copay, and plan pays 100%	Plan pays 80% ^
Outpatient Therapy Services		
Outpatient Physical Therapy	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Annual Limits: • Physical therapy – 30 visits • Limits are not applicable to mental health conditions. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.		
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Annual Limits: • Speech, hearing and occupational therapies – 60 visits • Limits are not applicable to mental health conditions for speech and occupational therapies. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Chiropractic Care	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Annual Limit: • Chiropractic care – 30 visits		
Hospice		
Inpatient Facilities	Plan pays 100% ^	Plan pays 80% ^
Outpatient Services	Plan pays 100% ^	Plan pays 80% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Medical Pharmaceutical Drugs		
Cigna Pathwell Specialty® Medical Pharmaceuticals	Plan pays 100% ^	Not Covered
Other Medical Pharmaceuticals	Plan pays 100% ^	Plan pays 80% ^
• Cigna Pathwell Specialty® Medical Pharmaceuticals are only covered when administered by a Cigna Pathwell Specialty® designated provider. • This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design.		
Family Planning		
Women's Services	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)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis	Covered same as plan's Home Health Care benefit	Covered same as plan's Home Health Care benefit

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Covered same as plan's Outpatient Professional Services benefit
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 80% ^
Organ Transplants • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® facilities. • Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: $10,000 maximum per Transplant	Covered same as Inpatient benefit	Covered same as Inpatient benefit
Condition-Specific Care • Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify. • Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply. • Travel Maximum - $600 per procedure	Plan pays 100%	Not Applicable
Durable Medical Equipment and External Prosthetic Appliances • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 80% ^
Wigs • Maximum of 1 wig per lifetime	Plan pays 100% ^	Plan pays 100% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 80% ^
Temporomandibular Joint Disorder (TMJ) • Annual Limit: Unlimited for Surgical and Non-Surgical treatment **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Hearing Aids • Annual Limit: Unlimited • Includes testing and fitting of hearing aid devices • Coverage through age 21	Plan pays 100% ^	Plan pays 80% ^
Acupuncture • Annual Limit: 20 visits	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		

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Note: Services where plan deductible applies are noted with a caret (^).		
Inpatient Mental Health	$250 per admission deductible, and plan pays 100%	Plan pays 80% ^
Outpatient Mental Health - Physician's Office	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Outpatient Mental Health - MDLIVE Behavioral Services	$45 copay, and plan pays 100% ^	Not Covered
Outpatient Mental Health - All Other Services	Plan pays 100%	Plan pays 80% ^
Inpatient Substance Use Disorder	$250 per admission deductible, and plan pays 100%	Plan pays 80% ^
Outpatient Substance Use Disorder - Physician's Office	$45 copay, and plan pays 100% ^	Plan pays 80% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	$45 copay, and plan pays 100% ^	Not Covered
Outpatient Substance Use Disorder - All Other Services	Plan pays 100%	Plan pays 80% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All other services - may include partial hospitalization, intensive outpatient services, Applied Behavior Analysis (ABA therapy), etc.

Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Pharmacy	In-Network	Out-of-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) • If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.	**Retail (per 30-day supply):** Generic: You pay $25 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $150 **Retail and Home Delivery (per 30-day supply):** Specialty: You pay $225 **Retail and Home Delivery (per 90-day supply):** Generic: You pay $50 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $300	**Retail:** You pay 20% Your plan pays 80% **Home Delivery:** Not Covered

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Pharmacy	In-Network	Out-of-Network

- **Member Choice Cigna 90 Now:** This network of pharmacies includes major retail chains of Walgreens and CVS, in addition to other grocery, retailer, and independent pharmacies. You will be aligned to either the Walgreens or CVS network based on your existing pharmacy relationship. Where no relationship exists, you will be aligned to plan sponsor elected CVS pharmacy. If that designation is not right for you, there is the option to select Walgreens. For more information, go to myCigna.com or call the number on the back of your ID card. Retail drugs for a 30-day supply may be obtained in-network at a wide range of pharmacies across the nation although prescriptions for a 90-day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: 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).
- Pharmacist will dispense the brand medication, and the patient will pay the generic cost share, when the medication is part of the Brand-for-Generic Substitution Program (DAW9).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **SaveOn Specialty Program:** Certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. All drugs in this program are potentially subject to a higher cost share than amounts set forth above. If you participate in the program, cost share may be paid through a manufacturer copay assistance program and your out-of-pocket cost may be reduced to $0. If you do not participate in the program, then you will be responsible for the payment of the cost share for these medications and payment will not be applied towards your deductible and out-of-pocket maximums. See your plan documents for more specific information.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- When using a glucagon-like peptide 1 (GLP-1), it is important to have extra clinical care and support from your doctor and pharmacist. There are pharmacies in your plan's network that can help including Evernorth EnGuide℠ Pharmacy.

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.
- Generic Non-Sedating Anti-histamines are covered.
- Oral Fertility drugs are covered.
- Generic Ulcer Drugs (Proton Pump Inhibitors/PPI) are covered.
- Lifestyle drugs are covered-limited to sexual dysfunction.

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Pharmacy Program Information

Pharmacy Clinical Management: Essential

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

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

Patient Assurance Program

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

- Any amount you pay for these medications 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.

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

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

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.

Out-of-Area Services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for Out-of-Area • Out-of-network deductible and out-of-pocket maximums apply.	For all other services, plan pays 80% after the out-of-network deductible is met

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, a $750 penalty will be applied.

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Additional Information

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

Well-Being Solution: Core Plus

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

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
- Non-emergency services incurred outside the United States
- Bariatric surgery - except when medical necessity guidelines are met

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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.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: MA

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Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

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, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711 :TTY) 1-800-244-6224

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vows parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره1-800-244-6224.ارائه‌دهنده خود صحبت کنید