01/01/2024
ME

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Deductible** | Individual - Employee Only: $3,200<br>Family Maximum: $6,400 | Individual - Employee Only: $3,200<br>Family Maximum: $6,400 |

The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
Plan deductible always applies before any benefit copay/deductible or coinsurance.
Plan deductible does not apply to in-network preventive services.
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.
This plan includes a combined Medical/Pharmacy plan deductible.
In-Network Generic as well as Preferred and Non-Preferred Brand preventive drugs and products included in the Preventive Plus Package will not be subject to deductible. This may apply to drugs for: Asthma, Cholesterol Lowering, Depression, Diabetes (including diabetic supplies and continuous glucose monitor supplies), Heart Disease and Stroke, High Blood Pressure, Osteoporosis, Prenatal Vitamins.

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

| | In-Network | Out-of-Network |
|---|---|---|
| **Plan Out-of-Pocket Maximum** | Individual - Employee Only: $3,200<br>Family Maximum: $6,400 | Individual - Employee Only: $6,400<br>Family Maximum: $12,800 |

The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.
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**<br>Plan pays 100% after plan deductible for the initial visit per Calendar Year.<br>First PCP Office Visit per year paid at no charge after applicable deductible. | Plan pays 90% ^ | Plan pays 70% ^ |
| **Specialty Care Physician Services/Office Visit** | Plan pays 90% ^ | Plan pays 70% ^ |
| **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Surgery Performed in Physician's Office** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Allergy Treatment/Injections and Allergy Serum**<br>Allergy serum dispensed by the physician in the office | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | Plan pays 90% ^ | Not Covered |
| Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).<br>Lab services supporting a virtual visit must be obtained through dedicated labs.<br>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies. | | |
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Specialty Care Physician Services/Office Visit** | Plan pays 90% ^ | Plan pays 70% ^ |
| Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).<br>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.<br>**NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Preventive Care** | | |
| **Preventive Care** | Plan pays 100% | PCP: Plan pays 70% ^<br>Specialist: Plan pays 70% ^ |
| Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.<br>Annual Limit: Unlimited | | |
| **Immunizations** | Plan pays 100% | PCP: Plan pays 70% ^<br>Specialist: Plan pays 70% ^ |
| **Mammogram, PAP, and PSA Tests** | Plan pays 100% | Covered same as other x-ray and lab services, based on Place of Service |
| Coverage includes the associated Preventive Outpatient Professional Services.<br>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service. | | |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Inpatient Professional Services** | Plan pays 90% ^ | Plan pays 70% ^ |
| For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 90% ^ | Plan pays 70% ^ |


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| Benefit | In-Network | Out-of-Network |
| --- | --- | --- |
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Outpatient Professional Services** | Plan pays 90% ^ | Plan pays 70% ^ |
| For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Emergency Services** | | |
| **Emergency Room**<br>Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. | Plan pays 90% ^ | Plan pays 90% ^ |
| **Urgent Care Facility**<br>Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit. | Plan pays 90% ^ | Plan pays 90% ^ |
| **Ambulance** | Plan pays 90% ^ | Plan pays 90% ^ |
| 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**<br>Annual Limit: 150 days | Plan pays 90% ^ | Plan pays 70% ^ |
| **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 90% ^ | Plan pays 70% ^ |
| **Outpatient Facility** | Plan pays 90% ^ | Plan pays 70% ^ |
| **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 90% ^ | Plan pays 70% ^ |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Outpatient Therapy Services** | | |
| **Outpatient Therapy and Chiropractic Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limits:<br>All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days | | |
| **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum. | | |
| **Cardiac Rehabilitation Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit:<br>Cardiac Rehabilitation - 36 days | | |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 100% ^ | Plan pays 70% ^ |
| **Outpatient Services** | Plan pays 100% ^ | Plan pays 70% ^ |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Bereavement Counseling (for services not provided as part of a hospice program)** | | |
| Services Provided by a Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Medical Pharmaceutical Drugs** | | |
| **Cigna Pathwell Specialty Medical Pharmaceuticals** | **Cigna Pathwell Specialty Network:**<br>Plan pays 90% ^ | Plan pays 70% ^ |
| **Other Medical Pharmaceuticals** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Note:** This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design. | | |
| **Maternity** | | |
| **Initial Visit to Confirm Pregnancy** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - |


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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.** | | |
| **Abortion** | | |
| **Abortion Services** | Plan pays 100% ^ | Coverage varies based on Place of Service |
| **Note:** Elective and non-elective procedures | | |
| **Family Planning** | | |
| **Women's Services** | Plan pays 100% | Coverage varies based on Place of Service |
| 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) | | |
| **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.<br>Lifetime Maximum: Unlimited | | |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care**<br>Annual Limit: Unlimited<br>16 hour maximum per day<br>**Note:** Includes outpatient private duty nursing when approved as medically necessary | Plan pays 90% ^ | Plan pays 70% ^ |

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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Acupuncture**<br>Annual Limit: 20 days | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | Plan pays 90% ^ | Plan pays 70% ^ |
| **Outpatient Mental Health – Physician's Office**<br>First MHSUD Office Visit per year paid at no charge after applicable deductible; subsequent visits will have a cost-share of no more than the primary care physician's office visit | | |


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| Pharmacy | In-Network | Out-of-Network |
| --- | --- | --- |
| **Cost Share and Supply** | | |
| **Cigna Pharmacy Cost Share**<br>Retail – up to 90-day supply<br>(except Specialty up to 30-day supply)<br>Home Delivery – up to 90-day supply<br>(except Specialty up to 30-day supply) | **Retail (per 30-day supply):**<br>Generic: You pay 10% ^<br>Preferred Brand: You pay 10% ^<br>Non-Preferred Brand: You pay 10% ^<br><br>**Retail and Home Delivery (per 90-day supply):**<br>Generic: You pay 10% ^<br>Preferred Brand: You pay 10% ^<br>Non-Preferred Brand: You pay 10% ^ | **Retail:**<br>You pay 30% ^ |



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## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.
**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

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

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

    In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
    - require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
    - deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
    - reduce the benefits in proportion to the amountlcost-share ph(to pnifin proa:3de)40000153 199.. g 【Coixclusion1(nefiOs.. g 【Co53 199( )1(p5Df


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cataract surgery.

Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Acupuncture.

All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.

Products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.

Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.

Membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.

Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

Dental implants for any condition.

Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of [illegible] are available to you. For current Cigna customers, call the number on the back of [illegible] 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: [illegible] 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[illegible]您免費提供語言協[illegible] 的現有客戶，請致電您的ID卡背面的號碼。[illegible]其他客戶請致電 1.8[illegible]

**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 [illegible] 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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

**Russian** – В[illegible] услуги перевод[illegible] 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 الإنتباه خدمات الترجمة المجانية [illegible] Cigna عملاء [illegible] 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, [illegible] nimewo ki dèyè kat ID ou. Sinon, rele [illegible]

**French** – ATTENTION: Des services d'aide linguistique vous [illegible] [illegible] veuillez appeler le numéro indiqué au verso de votre carte d'identit[illegible] Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência [illegible] gratuitos. Para clientes Cigna [illegible] número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para [illegible]

**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 [illegible] 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 [illegible] Cigna-Kunde sind, rufen Sie bitte [illegible] Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفا [illegible] 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 شماره‌گیری کنید).

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