EMPLOYEE
BENEFITS
GUIDE

Southeast Healthcare Partners

2026 - 2027

Rev. July 1, 2026

WELCOME

Dear Team Member,

As a new employee, we want to welcome you to a new career with our company. You can take pride in the fact that you are now a team member of a premier provider of skilled health care services. We strive to provide excellent care for our residents and will help you attain excellence in your career with us.

An important part of your compensation package are the employee benefits made available to all eligible employees. Eligible employees are those employees who are scheduled to work 30 or more hours per week. Eligible employees are benefits eligible on the first of the month following 60 days of full-time employment. This guide will give you an overview of all of your available insurance benefit choices.

Our H.R./ Benefits Team has worked hard to provide you with a broad choice of insurance benefits to protect you and your family in time of need. Please take the time to review the important information in this guide so you can make informed choices when selecting your benefits.

Please note, it is your decision whether to participate in any of the benefits offered. It is mandatory to review the benefit offerings during the month prior to your benefit eligibility and review your benefit choices. You can then enroll or decline any or all of the offerings.

To make the interview process easy, we have two ways for you to enroll:

By Phone

Call the Enrollment Call Center at (678) 918-8387. The enrollment call center is open for you to enroll or ask any benefit related questions from 9am-6pm EDT or 8am-5pm CDT, Monday - Friday.

Online

Visit metlife.benselect.com/SoutheastHC.
The username will be your full social security number and the password will be the last four digits of your social security number & the last two digits of your year of birth.

Plan Documents and Notices

Please visit the forms library section at metlife.benselect.com/SoutheastHC to review important benefit documentation for our plans, including the Benefit Guide, the Health and Welfare Plan Summary, the Medical Plan Summary, Dental and Vision plan summaries and other plan documents and required notices. The benefit guide provides a detailed description of each benefit. The forms library can be reached by clicking on the scroll icon in the upper right corner of the screen.

Thank you,
HR Team

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ELIGIBILITY

Employees who are scheduled to work 30 or more hours per week are eligible 1st of the month following 60 days of full time employment. Terminations due to termination of employment are effective as of employees' last day worked. You can elect medical, dental, and vision coverage for your spouse and dependent/adult children up to 26 years old. Your employer reserves the right to request proof of marriage and birth certificates in order to add dependents.

WHEN COVERAGE BEGINS AND ENDS

Your benefits become effective the 1st of the month following 60 days of hire provided you've submitted a completed enrollment with a benefit counselor within 30 days of your benefits effective date. Any applicable waiting periods or additional exceptions are covered under each benefit description.

Your coverage under the benefits plans will end the date on your last day worked, the day you no longer meet the plan's eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

QUALIFYING EVENTS

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a Qualifying Event.

These may include, but not limited to: Changes in employment status, legal marital status or number of dependents, taking an unpaid leave of absence, Dependent satisfies or ceases to satisfy eligibility requirement, a COBRA-qualifying event, Entitlement to Medicare or Medicaid, or a change in the place of residence of the employee, resulting in the current carrier not being available.

THINGS TO CONSIDER

Consider your personal situation and the difference between the plan options and their costs when making your decision. You may also elect to waive coverage.

Ask yourself the following questions
- Will your current doctor be in or out-of-network?
- Do you have any planned surgeries this year?
- How many family members will you cover?
- How often do you visit the doctor?
- Are you planning to have a baby this year?

By reading this guide cover to cover, you will become familiar with your benefits options. After enrolling, verify that your payroll deductions are correct. If not, please contact your payroll representative.

This enrollment booklet is a summary description of your benefits. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment. These plans are provided by your employer and employer's insurance broker. Although every effort has been made to provide complete and accurate information, we make no warranties, express or implied, or representations as to the accuracy of content on this booklet. We assumes no liability or responsibility for any error or omissions in the information contained in the booklet. View your plan summaries online at southeasthcbenefits.com/.

EMPLOYER PAID BENEFITS

BASIC LIFE INSURANCE

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employer Paid Life and AD&D

$30,000 Life and Accidental Death & Bodily Injury Insurance is provided to you as an employee. When you make your benefit elections you must elect a beneficiary to receive this benefit. If you feel you need additional life coverage, please refer to the supplemental life section on page 20.

This benefit is reduced by a percentage of Basic Term Life Insurance in force at age 64 when certain age milestones are reached:
35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80, and 85% at age 85

Employee Assistance Program (EAP)

We provide short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health, and make your life easier.

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions

Up to 3 in-person, telephonic, or video counseling sessions to help manage stress, anxiety & depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Financial Consultation

Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, & saving for retirement or tuition.

Life Management

Information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Medical Advocacy

Navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Legal Consultation

Help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Coaching

Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Personal Assistant

Manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining & personal services.

Member Portal and App

Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.

Live Webinars

Scheduled throughout the year to provide information on important topics. Webinar Schedule and Library: https://allonehealth.com/webinars/

Contact ACI Specialty Benefits

855-775-4357
rsli@acieap.com
Company Code: RSLI859
rsli.acieap.com

MEDICAL BENEFITS

In-Network Plan Details	BASE PLAN	OAP PLAN
Deductible (Single/Family)	$5,000 / $10,000	None†
Out-of-Pocket Limit (Single/Family)	$7,000 / $14,000	$8,000 / $16,000
Health care provider's office or clinic visit		
Primary care visit in person/virtual	20% Co-insurance*	$30 copay and plan pays 100%
Specialty Care visit in person/virtual	20% Co-insurance*	$40 copay and plan pays 100%
Surgery Performed in Office	20% Co-insurance*	Plan pays 100%
Telemedicine from MDLIVE	20% Co-insurance*	$30 copay $40 copay for Specialty Care services
Laboratory and Radiology Services		
Physician Services/Office Visit	20% Co-insurance*	Plan pays 100%
Independent Lab (Blood work only)	20% Co-insurance*	Plan pays 100%
Outpatient Facility	20% Co-insurance*	Plan pays 100%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Physician's Services/Office Visit	20% Co-insurance*	Plan Pays 100%
Outpatient Facility	20% Co-insurance*	$300 scan/day copay
Prescription Drugs	30 day Retail / 90 day Mail Order	
Generic (Tier 1)	$10* / $25*	$10 / $30
Preferred (Tier 2)	$30* / $75*	$35 / $105
Non-Preferred (Tier 3)	$50* / $125*	$55 / $165
Specialty (Tier 4)	$25%*	25%
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.		
Outpatient Therapy Services		
Physical Therapy (20 Visit annual Limit. Not Applicable to mental heal conditions)	20% Co-insurance*	$40 copay
Speech, Hearing & Occupational Therapy (20 Visit annual Limit)	20% Co-insurance*	$40 copay
Chiropractic Care (20 Visit annual Limit)	20% Co-insurance*	$40 copay
Outpatient Services		
Facility Services	20% coinsurance*	$1000/admission deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	20% coinsurance *	Plan pays 100%
Emergency Services		
Emergency room services	20% co-insurance*	$500 Copay
Emergency medical transit	20% coinsurance *	Plan pays 100%
Urgent Care	20% coinsurance *	$60 Copay

† There is a deductible of 100/individual or $200/family for prescription drugs; $1,000 for in-network outpatient hospital visit; $1,000 per day for in-network hospital stay. There are no other specific deductibles.

MEDICAL BENEFITS

	BASE PLAN	OAP PLAN
Inpatient Services		
Hospital Facility Services (Labs, Radiology, ARI, and medical specialty drugs)	20% co-insurance*	$1,000/day deductible, Limit 3/day deductibles annually
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	20% co-insurance*	Plan pays 100%
Skilled Nursing Facility, Rehab Hospital, Sub-Acute Facilities (Annual limit: 60 days)	20% co-insurance*	Plan pays 100%
Preventative Care		
Office Visits	Plan pays 100%	Plan pays 100%
Immunizations	Plan pays 100%	Plan pays 100%
Services	Plan pays 100%	Plan pays 100%
Preventative services include Mammogram, PAP Smear, Prostate Specific Antigen (PSA) and Colo-rectal Screenings.		
Mental Health and Substance Abuse Disorder		
All Outpatient services	20% co-insurance*	$ 40 copay
Inpatient services (Mental Health, Substance use Disorder)	20% co-insurance*	$1,000/day deductible, Limit 3/day deductibles annually
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” in the Benefit Summary.		
Family Planning		
Women’s Services	Plan pays 100%	Plan pays 100%
Includes contraceptive devices as ordered or pr prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Other Healthcare and Facility Services		
Home health care	20% co-insurance*	Plan pays 100%
Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)		
Organ Transplants	Covered same as Inpatient Benefit	Plan pays 100%
Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. Travel maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, $10,000 maximum per Transplant		
Condition-Specific Care	Plan pays 100%	Plan pays 100%
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 - After the deductible is met, $600 per procedure		
Durable Medical Equipment and External Prosthetic Appliances	20% co-insurance*	Plan pays 100%
Breast Feeding Equipment and Supplies	Plan pays 100%	Plan pays 100%
Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies		
Hospice Services	Plan pays 100%	Plan pays 100%
Inpatient Facilities and Outpatient Care		
Out of network Benefits		
Deductible (Single/Family)	$15,000 / $30,000	$5,000 / $10,000
Max out of pocket (Single/Family)	$19,050 / $38,100	$15,000 / $30,000
Co-insurance	40% Co-insurance	30% Co-insurance

*** Services where plan deductible applies**

MEMBER CHOICE BENEFITS

MDLIVE for Cigna offers reliable 24/7 health care by phone or video. Our national network of board-certified doctors, pediatricians, dermatologists, psychiatrists, and therapists provides personalized care for hundreds of medical and behavioral health needs. With an average of 10 years* of experience, MDLIVE doctors and therapists are dedicated to helping you get better and stay well on your schedule. No surprise costs. No hassle. Visit us at www.mdliveforcigna.com or call us at 888.726.3171

*MDLIVE credentialed providers as of 2021, subject to change.

URGENT CARE

When you're not feeling well or need care fast, have a visit in just minutes with an MDLIVE board-certified doctor.

- See a doctor in less then 15 minutes
- Reliable and affordable alternative to urgent care clinics
- Prescriptions available if appropriate

BEHAVIORAL HEALTH

Appointments are private, convenient, and affordable. You can choose the same provider for each visit or switch at any time.

Licensed Therapists

- With hundreds of licensed therapists in the MDLIVE network, it's easy to find a provider that is the right fit for you.
- Have your first therapy appointment in a week or less compared to the weeks or months it could take to schedule an in-person visit.

Board-Certified Psychiatrists

- MDLIVE board-certified psychiatrists can diagnose medical illnesses and prescribe and assess medication, when necessary.
- You're encouraged to build an ongoing relationship with your doctor.

PRIMARY CARE

MDLIVE for Cigna's convenient primary care option makes it easy to connect to a board-certified primary care physician (PCP) for routine care, or preventive care on a schedule that works for you.

Preventative Care with a Wellness Screening

- Your MDLIVE board-certified doctor will help identify any potential health issues, discuss ways to improve your health, and recommend follow-up care, if necessary.
- Your preventive care benefit includes a health risk assessment and wellness screenings which, with associated lab work for your visit, are covered at no cost to you.*
- Have labs, blood work, and biometrics completed at local facilities.**
- Receive referrals to specialists as appropriate.

Routine Care

- Routine care helps you manage ongoing conditions and establish a relationship with your Primary Care Provider (PCP).
- Your doctor will help manage your health and well-being through regular visits, labs, diagnostics, and specialist referrals, when appropriate.
- Receive prescriptions, if appropriate, that can be sent to a local or home delivery pharmacy.

*For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
**Limited to LabCorp and Quest labs contracted with MDLIVE for virtual primary care.

DERMATOLOGY

When you need to see a dermatologist, it's important to get care quickly. Now, you can connect easily with a board-certified dermatologist through MDLIVE for Cigna without the long wait. There's no appointment required.*

How to use Virtual Dermatology

- Access virtual dermatology by logging in and select 'Dermatology." No appointment is necessary.
- Choose a provider and describe your dermatology concern, and upload photos to your MDLIVE account.
- Get a diagnosis and treatment plan, usually within 24 hours.
- Prescriptions will be sent directly to your preferred pharmacy, if appropriate.
- Have follow-up questions? Message the dermatologist for 30 days after the visit at no additional cost.

*Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Please note: Cigna members must choose an "Anchor" pharmacy, CVS, or Walgreens

- If CVS or Walgreens isn't select, Cigna will ether go with the anchor pharmacy selected by the client (in this case CVS).
- This DOES NOT affect local retail pharmacies. Members can go to those whenever needed. No disruption. This only affects CVS and Walgreens customers.
- 90-day fills can only be ordered by certain local pharmacies. Members will have to connect with their pharmacy for further information. through

PHARMACY NETWORKS AND NURSE ADVOCATE

Your network options

Both networks have over 55,000 pharmacies* in them, including local independent pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop.

*** Network as of April 2023. Subject to change.**

Network with CVS	Network with Walgreens
• You can fill 30-day and 90-day supplies at any in-network retail pharmacy, including CVS. • Walgreens is not in this network. This means your plan may not cover any prescriptions you fill there.	• You can fill 30-day and 90-day supplies at any in-network retail pharmacy, including Walgreens. • CVS is not in this network. This means your plan may not cover any prescriptions you fill there.
• Both networks include the option to fill 90-day prescriptions through our home delivery pharmacy.	

Changing Your Pharmacy Network

1. Call customer service using the toll-free number on your Cigna HealthcareSM ID card. Let them know you'd like to change your pharmacy network.
2. When your new plan year starts, log in to the myCigna® App or myCigna.com®. Go to the profile page and follow the on-screen instructions.

Unsure about a fever? Have questions about a medication? We're here to help.

Cigna's no-cost Health Information Line puts you in touch with a personal nurse advocate* via chat or phone. They're here to answer your health questions and help you make the best choice for your needs.

Nurse advocates are available for questions like:

- I've had a fever for 2 days. Should I go to the emergency room?
- Is virtual care a good option for my needs?
- Is there a good orthopedic doctor in my area?
- I take a maintenance medication. How can I save on my prescription and get it delivered?

» **Chat**

Monday – Friday
9:00 a.m. – 8:00 p.m. EST
excluding holidays via myCigna.com or the myCigna® App.

» **Call**

24/7/365.
Just dial the number on the back of your Cigna ID card.

DENTAL BENEFITS

Plan Details	
Deductible: Individual/Family	$50/$150
Annual Maximum Benefit Per Person	$1,000, Class 1 applies
Class 1 Expenses - Preventative & Diagnostic Care	**100%, No Deductible**
Oral Exams	2/ Calendar year
Cleanings	2/ Calendar year
Routine X-rays	Bitewings: 2 per calendar year
Fluoride Application	1/ Calendar year for people under 19
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers (non-orthodontic)	No frequency limit for participants under age 19
Non-Routine X-rays	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Emergency Care to relieve pain Administrated at In Network Co-insurance	
Class 2 Expenses - Basic Restorative Care	**80% After Deductible**
Fillings	
Oral Surgery	
Surgical Extraction of Impacted Teeth	
Anesthetics	
Minor Periodontics	Various limitations depending on the service
Major Periodontics	Various limitations depending on the service
Root Canal Therapy / Endodontics	
Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Repairs - Crowns, Inlays	
Repairs - Dentures, Bridges	Reviewed if more than once
Brush Biopsy	
Class 3 Expenses - Major Restorative Care	**50% After Deductible**
Crowns / Inlays / Onlays	Replacement every 5 years
Stainless Steel / Resin Crowns	
Dentures	Replacement every 5 years
Bridges	Replacement every 5 years
Class 4 Expenses - Orthodontia	**Not Covered**

VISION BENEFITS

For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eye wear, contacts, and corrective vision services

Benefit Features	In-Network Member Cost	Out-of-Network Reimbursement
Eye Examination		
Eye Exam	$20 copay	Up to $45 Allowance
Retinal Screening	Up to $39	Not Covered
Materials / Eye wear (Either Glasses or Contacts)		
Single Vision Lenses	$20 Copay	Up to $32 Allowance
Lined Bifocal Lenses	$20 Copay	Up to $55 Allowance
Lined Trifocal Lenses	$20 Copay	Up to $65 Allowance
Lenticular Lenses	$20 Copay	Up to $80 Allowance
Frames	80% after $130 Allowance	Up to $71 Allowance
Contact Lenses (Elective)	Balance over $130 Allowance	Up to $105 Allowance
Contact Lenses (Therapeutic)	$0	Up to $210 Allowance
Oversize lenses	$0	Not Covered
Rose#1 and #2 Solid Tints	$0	Not Covered
Polycarbonate Lenses (Under 19 years of age)	$0	Not Covered
Standard Polycarbonate	$40	Not Covered
Standard Progressives	$65	Not Covered
Plastic Dye Tints	$15	Not Covered
Photochromic	$75	Not Covered
Standard Scratch Coating	$15	Not Covered
Standard UV Coating	$15	Not Covered
Standard Anti-Reflective Coating	$45	Not Covered
Hi-Index Lenses	20% Off Retail	Not Covered
All Other Lense Options	20% Off Retail	Not Covered
Service Frequencies		
Exams	Every calendar year	
Lenses (for glasses or contact lenses)‡‡	Every calendar year	
Frames	Every two calendar years	
In-Network Value Added Savings	Up to 40% off additional complete pairs of glasses. 20% off any item not covered by the plan, including non-prescription sunglasses, but excluding professional services.	

One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance

How to use your Cigna Vision Benefits

Finding a Doctor

- Log into myCigna.com, under "Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision – serviced by EyeMed Directory.
- Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click on Cigna Vision serviced by EyeMed Directory, from the Additional Directories drop down listing.
- Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative

Schedule and appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna Vision serviced by EyeMed information at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

Out-of-network plan reimbursement

Send a completed Cigna Vision service by EyeMed claim form and itemized receipt to: Cigna Vision, Claims Dept. c/oFAA
PO Box 8504, Mason, OH 45040-7111

To get a Cigna Vision serviced by EyeMed claim form:

- Go to Cigna.com and go to Forms, Vision Forms, select the Cigna Vision serviced by EyeMed form
- Go to myCigna.com and go to your vision coverage page

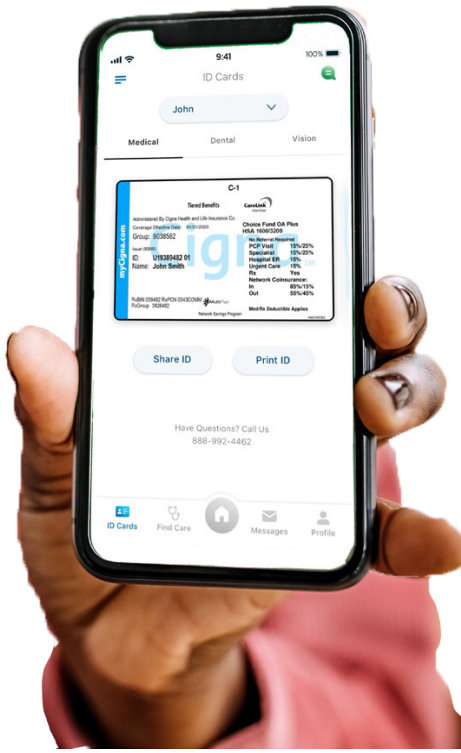
Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

ID CARDS
FINDING A PROVIDER

Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.

1. Log in to myCigna.com or the myCigna® App
2. Click or tap "ID Cards"
3. View your card(s), as well as any dependents' card(s)
4. Email cards directly to doctors
5. Save your digital ID cards in your Apple Wallet



Not registered on myCigna yet? Visit myCigna.com or scan the QR code to download the myCigna® App and register now.

Search our directory to find providers in four simple steps!

STEP 1 Go to Cigna.com and click on "Find a Doctor" at the top of the screen. Under "How are you covered?" select "Employer or School." (If you're already a Cigna customer, log in to myCigna.com or the myCigna® app to search your current plan's network.)

STEP 2 Change location to the city/state or zip you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

STEP 3 Answer any clarifying questions, and then verify where you live

STEP 4 Optional: Select one of the plans offered by your employer during open enrollment.

You can refine your search by distance, years in practice, specialty, languages spoken and more. Our directory search is just the beginning!

After you enroll, you'll have access to myCigna.com – your one-stop source for managing your health plan, anytime, just about anyplace. On myCigna.com, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

GROUP ACCIDENT

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

Benefit Amounts

Hospital, Surgery and Rehabilitation

Hospital Admission Max 2 per year	$1,500
Hospital Confinement 365 days maximum per accident	$225
Hospital intensive Care Unit Admission Max 2 per year	$2,000
Hospital Intensive Care Unit Confinement 30 days maximum per accident	$600
Hospital Observation Unit 1 day maximum per accident	$300
Exploratory Surgery 1 per accident	$150
Anesthesia 1 administration per accident	$25

Accidents and Injuries

Animal bite 1 shot per accident	$70
Burn 1 maximum treatment per accident	Up to $7,500
Burn Skin Graft 1 skin graft per accident	40% of burn benefit
Coma 1 per accident	$10,00
Concussion 1 per accident	$300
Dislocation *(doubles for open reduction)* 1 per accident	$4,000
Emergency Dental Work 1 repair per accident	$300
Eye Injury 1 surgery or removal of foreign object per accident	$75
Fracture *(doubles for open reduction)* *1 per accident*	Up to $5,250
Gunshot 1 maximum treatments per accident	$1,500
Knife Wound 1 maximum treatment per accident	50%
Ear Injuries 1 ear lifetime limit	Up to $200
Laceration 1 treatment per accident	Up to $600
Paralysis 1 per accident	Up to $12,500

Transportation

Ambulance - Air 1 per accident	$2,000
Ambulance - Ground or Water 1 per accident	$150
Transportation 3 times per accident	$250

Treatment and Follow-Up Care

Accident Emergency Initial Treatment maximum 2	$75
Accident Follow-Up Doctor Visit Maximum 2	$75
Ambulatory Surgical Center	$150
Blood/Plasma/Platelets 3 transfusions per accident	20%
Chiropractic Treatment and Alternative Therapy 6 visits per accidents	$25
Outpatient X-ray, Echocardiography and Cardiovascular Ultrasound max 1 total outpatient	$200
Outpatient X-ray, Echocardiography and Cardiovascular Ultrasound max 1 total outpatient	$200
Outpatient Injection max 1	$200
Outpatient Prescription Drugs 2 prescriptions per accident	$40
Pain Management 1 injection per accident	$30
Therapy: Occupational, Physical, or Speech max 3	$25

Additional Benefits

Appliance: Major (Minor is 1/2 Major) 1 per accident	$75
Lodging for Companion 30 days per accident	$125
Modification of Residence or Automobile 1 per accident	$1,250
Organized Sporting Activity *Percentage of Accident Maximum during 12 month period	25%*
Prosthetic Device/Artificial Limb 1 device per accident	$1,000
Service Dog	$200

Death and Dismemberment

Accidental Death	$25,000
Accidental Death - Common Carrier	$50,000
Accidental Dismemberment 1 per lifetime	$25,000

SHORT-TERM DISABILITY

PRESIDENTIAL LIFE INSURANCE

What is Short-Term Disability Insurance? Short-term- disability, or income replacement, is a type of insurance or employee benefit that provides financial support to individuals who are temporarily unable to work due to illness, injury, or a medical condition. It aims to protect employees' income during a limited period of incapacity, typically covering a portion of their salary for a short duration, facilitating their recovery without a significant financial burden.

Short Term Disability Benefits	
Total Disability Monthly Benefit	**Up to 60% of Salary**
Benefit Period	**3 Months**
Elimination Period Injury / Sickness	**0 / 7 or 14 / 14**
Guaranteed Issue	**$2,500 per month**
Partial Disability Benefit	**50% of Totals Disability Monthly Benefit 3 month Benefit Period**
Waiver of Premium Benefits	**Included**

Plan Features

Partial Disability
The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If, after being Totally Disabled, you remain partially disabled and are only able to work four hours per day, this plan will still pay you half of your selected monthly benefit for up to three months

Waiver of Premium
Premiums may be waived if you should become disabled

Elimination Period
Refers to the time period between an injury and you start receiving benefit payments. In this case you may select either 0 days for injury and 7 for sickness or 14 days for both when you sign up for this benefit.

Guaranteed Issue
The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Pre-Existing Condition Limitation
A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

LONG-TERM DISABILITY

Disability income protection insurance provides a benefit for long term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration

Long Term Disability Details	
Maximum Percentage of Income	60%
Monthly Benefit Maximum	$6,000
Elimination Period	90 days
Disability Definition	24 months Own Occupation
Benefit Duration	Extended-ADEA-B*
Survivor Benefit	3 Months
Worksite Modification	100% up to $2,000
Limitations	
Mental/Nervous/Substance	24 Months
Pre-Existing	12 / 12

Age Discrimination and Employment Act (ADEA). The ADEA requires that either the level of benefits or the costs of the benefit be the same for older employees as for younger employees.

Maximum Benefit Duration

Benefits will not extend beyond the longer of your Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
Prior to age 62	to age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Terms to Remember

Elimination Period
Refers to the time period between an injury and you start receiving benefit payments. In other words, it is the length of time between the beginning of an injury or illness and receiving benefit payments from your insurer.

Disability Definition
Generally, you are considered disabled, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment, and, you are unable to earn more than 80% of your pre-disability earnings at your own occupation.

Limitations
Your Disability benefits to a combined lifetime maximum for any and all of some conditions such as substance abuse or mental disorders is equal to the lesser 24 months or the maximum benefit period

Pre-Existing Condition
A pre-existing condition is defined as any sickness or injury (whether specifically diagnosed or not) for which the Insured received medical treatment, consultation, car or services, including diagnostic procedures or took prescribed drugs or medicines, during a specific period (as outlined in the policy) immediately prior to the Insured's effective date of coverage.

Benefit Duration
RDB w/SSNRA means that your benefits last until your social security normal retirement age unless you are 62 or older. In that case you would refer to the chart to the left.

Survivor Benefit
Your Policy provides a lump sum to the survivor of an insured person upon their death and had been receiving LTD benefits and had met the "Total Disability" definition for at least 180 days upon their death. The lump sum amount will equal three times the insured's net monthly benefit before death.

Own Occupation
An insured is considered disabled from his/her own occupation if unable, as a result of sickness or injury, to perform the material duties of his/her regular occupation as normally performed in the national economy

CRITICAL ILLNESS INSURANCE

PRESIDENTIAL LIFE INSURANCE

Critical illness insurance provides financial support in the event that you are diagnosed with a serious illness, such as cancer, heart attack, stroke, or kidney failure. These types of illnesses can be devastating not just emotionally and physically, but also financially. Medical bills, lost income, and other expenses can quickly add up and put a significant strain on your finances.

By purchasing critical illness insurance, you can have peace of mind knowing that you'll have financial support to help cover these expenses if you're ever faced with a serious illness. This can help alleviate some of the stress and anxiety that often comes with a diagnosis and allow you to focus on your recovery.

Benefits of Critical Illness Insurance:

1. **Maintain your lifestyle:** If you're unable to work due to a serious illness, critical illness insurance can help cover your living expenses so you can maintain your lifestyle and avoid dipping into your savings or retirement funds.

2. **Provide additional support:** Even if you have health insurance, the out-of-pocket expenses associated with a serious illness can be substantial. Critical illness insurance can provide financial support to help cover these costs.

3. **Customized to your needs:** Choose the level of coverage that best meets your needs and budget, have peace of mind knowing that you're covered in the event of a serious illness.

Critical illness insurance is a valuable investment for anyone who wants to protect themselves and their finances from the unexpected. While nobody likes to think about the possibility of being diagnosed with a serious illness, critical illness insurance provides a sense of security and peace of mind.

Plan Benefits

Cancer	
Non-Invasive Cancer	25%
Skin Cancer	$250
Heart	
Heart Attack	100%
Heart Transplant	100%
Stroke	100%
Angioplasty	25%
Aortic Surgery	25%
Coronary Artery Bypass Surgery	25%
Heart Valve Replacement/Repair Surgery	25%
Major Events	
Coma	100%
Kidney Failure (ESRD)	100%
Major Organ Transplant, other than heart	100%
Paralysis	100%
Other Covered	
Advanced Alzheimer's Disease, Advanced Parkinson's Disease, and Loss of Hearing, Sight, Speech	

Additional Coverages may include Transient Ischmeic Attack and Benign Brain Tumor. Please review Certificate for full coverage information.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

What Makes us Unique

Reoccurence and Additional Diagnosis

If you have a reocurrence or an additional diagnosis of a Critical Illness Benefits may be payable for the same Critical illness as outlined in your Certificate of Coverage.

PRESIDENTIAL LIFE INSURANCE

HOSPITAL INDEMNITY INSURANCE

Life is unpredictable. Without any warning, an illness or injury can lead to a hospital confinement and medical procedures and/or visits, which mean costly out-of-pocket expenses.

Base Benefits

Hospital Confinement Benefit

We will pay the amount in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident

Wellness and Preventative Care Benefit

For each day that an Insured receives Wellness and Preventive Care under the supervision of a Physician, We will pay the Benefit Amount shown in the Certificate Schedule of Benefits.

Hospital Indemnity Benefits

	Plan 1
Inpatient Hospital Admission (per admission)	$1,000
Inpatient Hospital Confinement (per day)	$250
ICU Confinement (per day)	$250
Wellness and Preventive Benefit	$50

Hospital Admission Benefit

The Company will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

Hospital Intensive Care Unit Benefit

When an Insured is confined in and charged for a Hospital Intensive Care Unit for treatment of a Sickness or an Injury, the Company will pay the Daily Hospital Intensive Care Unit Benefit shown in the Certificate Schedule of Benefits for each day an Insured is confined in and charged for a Hospital Intensive Care Unit.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/ symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

PERMANENT LIFE INSURANCE

PRESIDENTIAL LIFE INSURANCE

Term Life Benefit Amounts	
Covered Individual	**Coverage Limits**
Employee	up to $75,000
Spouse	the lesser of 50% of Employee's elections up to a max of $37,500
Child(ren)	up to $10,000 as long as the Employee has equal or more coverage on themselves

Restoration Rider

When the Lifetime Benefit Term Death Benefit is reduced below the Restoration Face Amount by the Accelerated Death Benefit for Long Term Care Rider, this Rider restores the Lifetime Benefit Term Death Benefit up to the Restoration Face Amount while this Rider is in force.

Accelerated Death Benefit for Long Term Care Rider

Death benefits will be reduced is an Accelerated Death Benefit is paid. The Accelerated Death Benefit or lien, if applicable, and the balance of the death benefit provided by the Certificate shall constitute full settlement on death of the Insured as provided under the Certificate.

This Rider provides that you may elect to receive a portion of the Death Benefit provided by the Certificate and shown on the Certificate Schedule. You can make this election when the Insured becomes eligible for benefits. The Insured must be certified as Chronically Ill and be confined to a Nursing or Assisted Living Facility or be receiving Home health or Adult Day Care. All other conditions of this Rider must also be met. Benefits are not payable under this Rider once the Insured has died.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

- An Initial Guaranteed Death Benefit until the latter of 25 years after the Coverage Date or age 70, but not beyond age 100. After this initial Period, a Reduced Guaranteed Death Benefits of 50% of the Initial Guaranteed Death Benefit is provided until age 121.
- Guaranteed Paid-Up Term benefits upon termination of payments after premiums have been paid for 10 full Coverage Years.
- Non-Guaranteed Paid-Up Term Benefits that may increase the Guaranteed Paid-Up Term benefit upon termination of premium payments after premiums have been paid for 10 full Coverage Years.
- After the Initial Guaranteed Death Benefit period, non-guaranteed One Year term Insurance which may increase the Reduced Guaranteed Death Benefit up to the Initial Guaranteed Death Benefit.
- Level Guaranteed Premiums payable to age 100.
- The Policy is non-participating and provides no cash surrender values or loan values.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

SUPPLEMENTAL LIFE AND AD&D

Supplemental Life and AD&D		
Covered Individual	**Benefit Amount**	**Guarantee Issue**
Employee	$10,000 to $500,000* in increments of $10,000	$200,000
Spouse	Up to 50% of Employee Benefit in increments of $5,000	$50,000
Child(ren)	$1,000 to $10,000 in increments of $1,000	$10,000

Supplemental life and AD&D is in addition to the employer paid life listed on page 5

*Supplemental coverage is limited to the lesser of $500,000 or 5 times your annual earnings.

Guaranteed Issue

The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Portability of Coverage

If you cease employment with your employer, you may elect to continue your coverage. You must have been continuously insured for at least 12 months under this plan and/or the prior plan just before the date your employment terminated.

Conversion

If an Insured Person's employment terminates for any reason, he/she may convert this coverage to an individual accident policy unless he/she is no longer eligible because of age or termination of the Policy. No medical examination or other evidence of insurability is needed regardless of age or state of health as long as application is made and the first premium is paid within 31 days after the coverage ends

Dependents

You must be insured for your dependents to be covered.
Dependents are:

- Your legal spouse who is not legally separated or divorced from you
- Your unmarried financially dependent children birth to 26 years
- A person may not have coverage as both an Employee and Dependent
- Only one insured spouse may cover dependent children

Benefit Reduction Due to Age

At age 70 the guarantee issue provision no longer applies, and the original benefit is reduced to 65%. Further reductions occur at age 75 (45%), 80 (30%), 85 (20%), & 90 (15%)

LEGAL SERVICES

MetLife

Unlike other voluntary benefits which are purchased as a safety net (with the hope that you never have to use them), the more you use a Legal Plan, the more you benefit. Like it or not, laws permeate every aspect of our lives. So, it's helpful to have an advocate in your corner dealing with expensive legal issues like identity theft or debt.

Plan Features			
Money Matters	Debt Collection Defense Financial Education Programs Identity Theft Defense	Identity Restoration Services Negotiations with Creditors Personal Bankruptcy	Promissory Notes Tax Audit Representation Tax Collection Defense
Home & Real Estate	Boundary & Title Disputes Mortgages Security Deposit Assistance Deeds	Property Tax Assessments Tenant Negotiations Eviction Defense Refinancing & Home Equity Loan	Zoning Applications Foreclosure Sale or Purchase of Home
Estate Planning	Codicils Living Wills	Revocable & Irrevocable Trusts Complex Wills	Complex Wills Powers of Attorney
Family & Personal	Adoption Guardianship Prenuptial Agreement Affidavits Immigration Assistance Protection from Domestic Violence	Conservatorship Juvenile Court Defense, Review of ANY Personal Legal Demand Letters Including Criminal Matters Document Divorce (20 hours)	Name Change School Hearings Garnishment Defense Parental Responsibility Matters Personal Properties Issues
Civil Lawsuits	Administrative Hearings Disputes Over Consumer Goods & Services	Pet Liabilities Civil Litigation Defense	Small Claims Assistance Incompetency Defense
Elder-care Issues	Consultation & Document Review for Issues Related to Your Parents: Medicaid Powers of Attorney	Medicare Prescription Plans Deeds Notes	Wills Leases Nursing Home Agreements
Traffic & Other Matters	Defense of Traffic Tickets Driving Privileges Restoration	Habeas Corpus Repossession	License Suspension Due to DUI
Family Coverage $9.85 per pay period			

MetLife

IDENTITY PROTECTION

Meet Aura

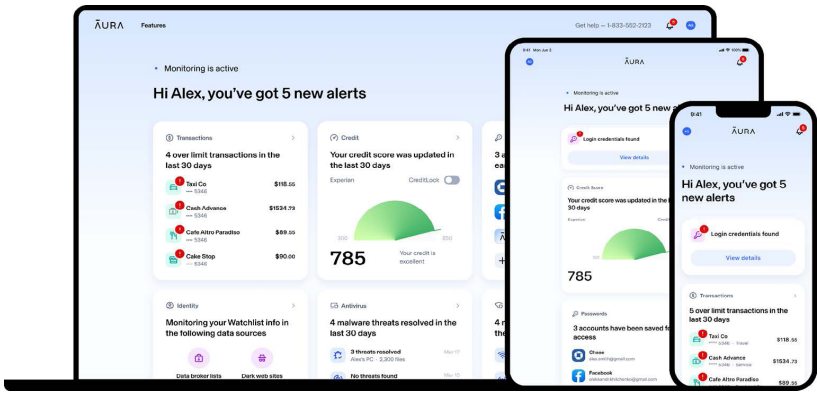
An all-in-one, easy to use online security solution designed to protect the entire family

Identity Theft Protection
Aura monitors your personal information and alerts you if any threats are detected.

Financial Fraud Protection
Aura monitors your credit, financial accounts, and property titles and alerts you to any suspicious activity.

Privacy and Device Security
Get intelligent safety tools– like VPN, antivirus, password manager, and more – to protect your online privacy.

Family Safety
Loved ones with integrated parental controls, elder fraud prevention tools, and more.



In today's digital world, employees are spending more time online than ever which could put their personal information in the hands of cyber criminals.

Aura protects you and your families from fraud by helping to ensure your private information is not anywhere it shouldn't be.

24/7/365 Customer Support	White Glove Fraud Resolution	$5,000,000 Insurance Policy	Features at your fingertips
Aura's 100% US-based Customer Support team is available 24/7/365.	Aura's White Glove Resolution Specialists guide fraud victims through every step of the remediation process.	Each enrolled adult is backed by a generous $5M insurance policy* to cover eligible losses and expenses.	With Aura's easy to use mobile app, members enjoy a consistent experience across devices.

Protection Plan	Protection Plus Plan
1 Bureau credit monitoring & alerts	3 Bureau credit monitoring & alerts
2 Device limit: Anti-virus, Wifi Scanning & VPN	Unlimited Devices: Anti-virus, Wifi Scanning & VPN
	Social Media Monitoring & Takeover Alerts
Individual $ 3.23 per pay period	Individual $ 4.23 per pay period
Family $5.48 per pay period	Family $6.98 per pay period

PET INSURANCE

MetLife

MetLife Pet Insurance is committed to helping pet parents experience the joys of parenthood by providing them the confidence to care for their pet. Pet insurance helps to reimburse pet parents for covered unexpected veterinary expenses for their furry family members. This will help to give you the confidence that you can pay for treatment for your pets if they become sick or have an accidental injury.

Freedom of Comprehensive coverage

Flexibility to select various levels of coverage with no breed exclusions or upper age limits; ability to include multiple pets on one policy through our innovative family plans

- Optional wellness coverage (preventive care) included in annual limit
- Competitive rates with discounts, healthy pet incentive and the only provider offering family plans (i.e., multiple pets covered by one policy)
- Coverage of pre-existing conditions when switching providers, no initial exam or previous vet records to apply

Simple and delightful experience

Your home is perhaps your most valuable possession, so you'll want to make sure your in New mobile app experience that allows for easy claim submission & track claims with most claims processed within 10 days

• Team of pet advocates to assist with enrollment and service, access to telehealth concierge service.

• No waiting period for orthopedic coverage and among the industry's shortest wait period for accident and illness coverage.

Backed by MetLife's unmatched track record

Simple set up with no additional costs to you and a seamless integration across MetLife benefits. Ongoing support with customizable employee communications & tools

Umbrella Insurance

You work hard for the things that are important to you. For added coverage above and beyond the liability limits of your Auto or Home insurance policies, a Personal Umbrella insurance policy can provide added protection for your assets and future earnings

This benefit is not payroll deducted. Premiums must be paid directly to MetLife.

MetLife

HOME & AUTO INSURANCE

Insure what's important while enjoying saving

- **Automated payment options and discounts**
- **Claim-free driving rewards**
- **Multi-policy savings**
- **Roadside assistance**
- **24/7 claim reporting**

Access to quality insurance to protect your valuables, to help protect against personal liability, and that can help feel financially secure with 24/7 professional support they need to bounce back, if the unexpected happened. This program helps choose policies to fit your needs and that fit your budget with special savings based on where you work, among other discounts.

Auto Insurance
Comprehensive coverage? Collision coverage? Deductibles? Medical Payments? Where to begin? Your local Farmers agent can take the mystery out of selecting the right Car insurance coverage for your needs and budget. Get started with an online Auto insurance quote and learn about our insurance discounts that can help you save money.

Home Insurance
Your home is perhaps your most valuable possession, so you'll want to make sure your insurer has withstood the test of time. Farmers® has been providing insurance products for over 80 years, and will be there in the event disaster strikes and your home is damaged in a fire or due to another covered cause of loss. Plus, get competitive rates with our multi-line insurance discounts. Get a Home insurance quote now.

Renters Insurance
Your landlord may have an insurance policy, but if there's a fire in your building, that policy may not cover your possessions. That's why there's Renters insurance. Get a Renters insurance quote to see how affordable it is to protect your personal belongings: about the price of a movie and popcorn once a month.

Umbrella Insurance
You work hard for the things that are important to you. For added coverage above and beyond the liability limits of your Auto or Home insurance policies, a Personal Umbrella insurance policy can provide added protection for your assets and future earnings

This benefit is not payroll deducted. Premiums must be paid directly to MetLife.

CARRIER CONTACT INFORMATION

BenManage

For assistance understanding and enrolling your benefits, reach the enrollment call center at **(678) 918-8387** Monday-Friday 8am-5pm CST

Below is contact information for each of the carriers of the specific benefits available to you for when you need to make a claim or have questions relating to a specific condition, coverage, or loss.

Carrier Contact Information			
Benefit Enrollment Center	BenManage	(678) 918-8387	
Employee Assistance Program	ACI Specialty Benefits	(855) 775-4357	rsli.acieap.com
Medical Benefits	Cigna Healthcare	(866) 494-2111	mycigna.com
Pharmacy	Cigna Healthcare	(800) 997-1654	mycigna.com
Behavioral Health & Telemedicine	MDLIVE	(888) 726-3171	mdliveforcigna.com
Dental	Cigna Healthcare	(866) 494-2111	mycigna.com
Vision	Cigna Healthcare	(866) 494-2111	mycigna.com
Short Term Disability	Presidential Life	(855) 639-7542	plicvb.com
Accident	Presidential Life	(855) 639-7542	plicvb.com
Critical Illness	Presidential Life	(855) 639-7542	plicvb.com
Hospital Indemnity	Presidential Life	(855) 639-7542	plicvb.com
Permanent Life Insurance	Presidential Life	(855) 639-7542	plicvb.com
Long Term Disability, Employer Paid and Supplemental Life and AD&D	Reliance Standard	(800) 351-7500	reliancematrix.com
Legal Services	METLIFE	(800) 821-6400	legalplans.com
Identity Theft Protection	METLIFE	(800) 638-5433	metlife.com
Pet Insurance	METLIFE	(855) 591-7121	quote.metlifepetinsurance.com
Home & Auto Insurance	METLIFE with Farmers	877-330-6238 discount code: FSU	metlife.com

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the Plan—your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) – If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You will be required to submit a signed statement that this other coverage is the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program –
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption –
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage: The Southeast HC Partners LLC group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

- TERMINATION OF MEDICAID OR CHIP COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the team member or dependent under such a plan is terminated as a result of loss of eligibility.
- ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Human Resources Department.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact the Human Resources Department for additional information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to the benefit summaries for the deductible and coinsurance for your plan.

Qualified Medical Child Support Order (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Newborn Acts Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following

a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage Extension Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits.
Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Patient Protection Disclosure

Southeast HC Partners LLC Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization 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, contact the Human Resources Department.

Genetic Information Non-Discrimination Act (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

ACA Section 1557 Compliance

Southeast HC Partners LLC ("Employer") complies with any applicable Federal and state civil rights laws regarding discrimination on the basis of race, color, national origin, age, disability or sex in respect of this medical plan, and shall administer, interpret, amend and construe the Plan benefits and exclusions to the extent such laws are deemed applicable, as determined by Southeast HC Partners LLC in its sole discretion.

Southeast HC Partners LLC provides free aids and services to people with disabilities to communicate effectively with the Plan, 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 are in need of these services, please contact the Human Resources Department.

If you believe the Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, a grievance may be filed with: Southeast HC Partners LLC HR Department. A grievance may be filed in person or by mail, fax, or email.

A civil rights complaint may also be filed 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your Information. Your Rights. Our Responsibilities.

This notice is presented in conjunction with the August 1, 2026 medical insurance renewal for Southeast Healthcare and its subsidiaries. This notice will remain in effect until replaced by subsequent updated notices. For further information on the notice, please contact Human Resources at 770-992-0441.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Southeast HC Partners LLC
Open Access Plus Plan
OAP
Effective - 08/01/2026

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.

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 70%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: None Family: None	Individual: $5,000 Family: $10,000

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and 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.
- Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $8,000 Family: $16,000	Individual: $16,000 Family: $32,000

- 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 (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 70% ^
Surgery Performed in Physician's Office	Plan pays 100%	Plan pays 70% ^
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	$30 copay, and plan pays 100%	Not Covered
MDLIVE Primary Care Services	$30 copay, and plan pays 100%	Not Covered
MDLIVE Specialty Care Services	$40 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.

Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$40 copay, and plan pays 100%	Plan pays 70% ^

- 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	$30 copay, and plan pays 100%	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 70% ^
Preventive Services • 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.	Plan pays 100%	Plan pays 70% ^
Immunizations	Plan pays 100%	Plan pays 70% ^
Inpatient		
Inpatient Hospital Facility Services • Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs	$1,000 per day deductible, and plan pays 100% Limited to 3 per day deductibles annually	Plan pays 70% ^
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 70% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%	Plan pays 70% ^
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit deductible.	$1,000 per admission deductible, and plan pays 100%	Plan pays 70% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%	Plan pays 70% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI) • Per visit copay is waived if admitted.	$500 copay, and plan pays 100%	
Urgent Care Facility • Includes Physician Charges, Lab and Radiology	$60 copay, and plan pays 100%	Plan pays 70% ^
Ambulance • Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 100%	
Ambulance - Mental Health and Substance Use Disorder • Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 100%	
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 100%	Plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100%	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 70% ^
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 100%	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	$300 scan per day copay, and plan pays 100%	Plan pays 70% ^
Physician's Services/Office Visit	Plan pays 100%	Plan pays 70% ^
Outpatient Therapy Services		
Outpatient Physical Therapy Annual Limits: • Physical therapy – 20 visits • Limits are not applicable to mental health conditions. • Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.	$40 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy Annual Limits: • Speech, hearing and occupational therapies – 20 visits • Limits are not applicable to mental health conditions for speech and occupational therapies. • Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.	$40 copay, and plan pays 100%	Plan pays 70% ^
Chiropractic Care Annual Limit: • Chiropractic care – 20 visits	$40 copay, and plan pays 100%	Plan pays 70% ^
Hospice		
Inpatient Facilities	Plan pays 100%	Plan pays 70% ^
Outpatient Services • Includes Bereavement counseling provided as part of a hospice program.	Plan pays 100%	Plan pays 70% ^
Medical Pharmaceutical Drugs		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Cigna Pathwell Specialty® Medical Pharmaceuticals	Plan pays 100%	Not Covered
Other Medical Pharmaceuticals	Plan pays 100%	Not Covered
• 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
• Elective and non-elective procedures		
Infertility		
Infertility Treatment • 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.		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Not Covered
Home Dialysis • Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit	Not Covered
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Not Covered
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Not Covered
Other Health Care Facilities/Services		
Home Health Care	Plan pays 100%	Plan pays 70% ^
• Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Organ Transplants	Covered same as Inpatient benefit	Not Covered
• 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		
Condition-Specific Care	Plan pays 100%	Not Applicable
• 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		
Durable Medical Equipment and External Prosthetic Appliances • Annual Limit: Unlimited	Plan pays 100%	Plan pays 70% ^
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 70% ^
Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	$1,000 per day deductible, and plan pays 100% Limited to 3 per day deductibles annually	Plan pays 70% ^
Outpatient Mental Health - Physician's Office	$40 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Mental Health - MDLIVE Behavioral Services	$40 copay, and plan pays 100%	Not Covered
Outpatient Mental Health - All Other Services	Plan pays 100%	Plan pays 70% ^
Inpatient Substance Use Disorder	$1,000 per day deductible, and plan pays 100% Limited to 3 per day deductibles annually	Plan pays 70% ^
Outpatient Substance Use Disorder - Physician's Office	$40 copay, and plan pays 100%	Plan pays 70% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	$40 copay, and plan pays 100%	Not Covered
Outpatient Substance Use Disorder - All Other Services	Plan pays 100%	Plan pays 70% ^
• 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. • 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." Annual Limits: • Unlimited maximum		

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 $10 Preferred Brand: You pay $35 Non-Preferred Brand: You pay $55 Specialty: You pay 25% **Retail (per 90-day supply):** Generic: You pay $25 Preferred Brand: You pay $88 Non-Preferred Brand: You pay $138 **Home Delivery (per 90-day supply):** Generic: You pay $30 Preferred Brand: You pay $105 Non-Preferred Brand: You pay $165 **Home Delivery (per 30-day supply):** Specialty: You pay 25%	**Retail:** You pay 30% Your plan pays 70% **Home Delivery:** Not Covered

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.
- If a generic is available, you pay the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (MAC A).
- 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.
- **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.

Pharmacy Deductible	Individual: $100 Family: $200

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.
- Prescription vitamins 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 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 $250 penalty will be applied.

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 out-of-network 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
- Hearing aids
- 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

Exclusions

- Treatment of TMJ disorders and craniofacial muscle disorders

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: GA

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Southeast HC Partners LLC
OAP HDHPQ Plan
HDHPQ OAP
Effective - 08/01/2026

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.

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 80%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual - Employee Only: $5,000 Individual - within a Family: $5,000 Family Maximum: $10,000	Individual - Employee Only: $15,000 Individual - within a Family: $15,000 Family Maximum: $30,000

- 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.
- 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 preventive drugs and products included in the preventive package will not be subject to deductible. This may apply to drugs for: Asthma, cholesterol lowering, depression, diabetes (including diabetic supplies but excluding continuous glucose monitor supplies), heart disease and stroke, high blood pressure, osteoporosis, prenatal vitamins.
- Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual - Employee Only: $7,000 Individual - within a Family: $7,000 Family Maximum: $14,000	Individual - Employee Only: $19,050 Individual - within a Family: $19,050 Family Maximum: $38,100

- 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	Plan pays 80% ^	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Surgery Performed in Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 80% ^	Not Covered
MDLIVE Primary Care Services	Plan pays 80% ^	Not Covered
MDLIVE Specialty Care Services	Plan pays 80% ^	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.

Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	Plan pays 80% ^	Plan pays 60% ^

- 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
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Convenience Care Clinic		
Convenience Care Clinic	Plan pays 80% ^	Plan pays 60% ^
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 60% ^
Preventive Services • 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.	Plan pays 100%	Lab & X-ray: Plan pays 100%; All other services: Plan pays 60% ^
Immunizations	Plan pays 100%	Plan pays 60% ^
Inpatient		
Inpatient Hospital Facility Services • Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs	Plan pays 80% ^	Plan pays 60% ^
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Outpatient		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)	Plan pays 80% ^	
Urgent Care Facility • Includes Physician Charges, Lab and Radiology	Plan pays 80% ^	Plan pays 60% ^
Ambulance • Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	
Ambulance - Mental Health and Substance Use Disorder • Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 60 days	Plan pays 80% ^	Plan pays 60% ^

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.		
Laboratory Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	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% ^
Outpatient Therapy Services		
Outpatient Physical Therapy Annual Limits: • Physical therapy – 20 visits • Limits are not applicable to mental health conditions. • Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.	Plan pays 80% ^	Plan pays 60% ^
Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy Annual Limits: • Speech, hearing and occupational therapies – 20 visits • Limits are not applicable to mental health conditions for speech and occupational therapies. • Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.	Plan pays 80% ^	Plan pays 60% ^
Chiropractic Care Annual Limit: • Chiropractic care – 20 visits	Plan pays 80% ^	Plan pays 60% ^
Hospice		
Inpatient Facilities	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services • Includes Bereavement counseling provided as part of a hospice program.	Plan pays 80% ^	Plan pays 60% ^
Medical Pharmaceutical Drugs		

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.		
Cigna Pathwell Specialty® Medical Pharmaceuticals	Plan pays 80% ^	Not Covered
Other Medical Pharmaceuticals	Plan pays 80% ^	Not Covered
• 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
• Elective and non-elective procedures		
Infertility		
Infertility Treatment • 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.		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Not Covered
Home Dialysis • Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit	Not Covered
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Not Covered
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Not Covered
Other Health Care Facilities/Services		
Home Health Care	Plan pays 80% ^	Plan pays 60% ^
• Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)		

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.		
Organ Transplants	Covered same as Inpatient benefit	Not Covered
• Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® facilities. • Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: After the plan deductible is met, $10,000 maximum per Transplant		
Condition-Specific Care	Plan pays 100% ^	Not Applicable
• 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 - After the deductible is met, $600 per procedure		
Durable Medical Equipment and External Prosthetic Appliances • Annual Limit: Unlimited	Plan pays 80% ^	Plan pays 60% ^
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 60% ^
Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 80% ^	Plan pays 60% ^
Outpatient Mental Health - Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient Mental Health - MDLIVE Behavioral Services	Plan pays 80% ^	Not Covered
Outpatient Mental Health - All Other Services	Plan pays 80% ^	Plan pays 60% ^
Inpatient Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^
Outpatient Substance Use Disorder - Physician's Office	Plan pays 80% ^	Plan pays 60% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	Plan pays 80% ^	Not Covered
Outpatient Substance Use Disorder - All Other Services	Plan pays 80% ^	Plan pays 60% ^
• 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. • 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." Annual Limits: • Unlimited maximum		
Pharmacy	**In-Network**	**Out-of-Network**
Cost Share and Supply		

Pharmacy	In-Network	Out-of-Network
Med 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.	Once the medical deductible is met then the customer is responsible for the cost share **Retail (per 30-day supply):** Generic: You pay $10 ^ Preferred Brand: You pay $30 ^ Non-Preferred Brand: You pay $50 ^ **Retail and Home Delivery (per 30-day supply):** Specialty: You pay 25% ^ **Retail and Home Delivery (per 90-day supply):** Generic: You pay $25 ^ Preferred Brand: You pay $75 ^ Non-Preferred Brand: You pay $125 ^	Once the medical deductible is met then the customer is responsible for the coinsurance **Retail:** You pay 0% ^ Your plan pays 100% ^ **Home Delivery:** Not Covered

- **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.
- You can elect brand or generic with no penalty (MAC C).
- 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.
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- 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.

Pharmacy	In-Network	Out-of-Network

Preventive Drugs:
Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, in-network generic preventive drugs and products included in the preventive package will not be subject to deductible and will be provided at no charge. This may apply to drugs for:

Asthma, cholesterol lowering, depression, diabetes (including diabetic supplies but excluding continuous glucose monitor supplies), heart disease and stroke, high blood pressure, osteoporosis, prenatal vitamins

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%.
- Prescription vitamins 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.

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.

Additional Information

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 • In-network deductible and out-of-pocket maximums apply.	For all other services, plan pays 80% after the in-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 $250 penalty will be applied.

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

Exclusions

- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- 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
- Treatment of TMJ disorders and craniofacial muscle disorders

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: GA

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

SEMI-MONTHLY BENEFIT RATES

Medical	Base Plan	Open Access Plus
Employee Only	$82.65	$277.00
Employee & Spouse	$547.00	$824.68
Employee & Child(ren)	$477.56	$742.83
Family	$1,000.54	$1,359.77
	Dental	**Vision**
Employee Only	$3.69	$0.99
Employee & Spouse	$17.62	$1.99
Employee & Child(ren)	$15.45	$1.88
Family	$26.00	$2.97

KEY TERMS TO REMEMBER

COINSURANCE
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

DEDUCTIBLE
The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

COPAYMENT
A flat fee that you pay toward the cost of covered medical services.

OPEN ACCESS PLUS (OAP)
Open Access Plus (OAP) plans make it easy to get quality, in-network care with access to a large, national network of providers. Plus, you have the option to choose a primary care provider to coordinate your care and you don't need specialist referrals.

CO-INSURANCE
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

IN-NETWORK
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

OUT-OF-NETWORK
Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and play payments are SUBJECT to deductibles and copayments.

OUT-OF-POCKET MAXIMUM (OOPM)
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

USUAL, CUSTOMARY AND REASONABLE (UCR)ALLOWANCE
The fee paid for services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure, (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.