TAKE CONTROL OF YOUR HEALTH.

Body & mind.

A guide to your UTGME benefit plan options.

PLAN YEAR: 07/01/2020 - 07/01/2021

Together, all the way.®

Cigna®

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A guide to your UTGME benefit plan options

Page

Words to know

This guide was created to help you make important decisions about your health care. Before you begin, we think that understanding certain words will help you better understand the choices you need to make. So here are some definitions of words and phrases that you'll see in this guide.

Deductible: An annual amount you'll pay out-of-pocket before your plan begins to pay for covered health care costs.

Copay: A preset amount you pay for your covered health care services. The health plan pays the rest.

Coinsurance: Your share of the cost of your covered services. The health plan pays the rest.

Out-of-pocket maximum: The most you pay before the health plan begins to pay 100% of covered charges. You'll still need to pay for any expenses the health plan doesn't count toward the limit.

In-network: Health care providers and facilities that have contracts with Cigna to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

Out-of-network: A health care provider or facility that doesn't participate in your plan's network and doesn't provide services at a discounted rate. Using an out-of-network health care provider or facility will cost you more.

Generics: Generic medications have the same active ingredients, strength and dosage as the brand-name but often cost less.

Preferred brand: You'll often pay more for a preferred brand-name medication than for a generic. Preferred brands may also have a lower-cost generic alternative available.

Non-preferred brands: These high-cost medications have lower-cost generic or preferred brand alternatives which are used to treat the same condition.

Ways to get better health

Cigna wants to help you choose benefits that fit your needs and help keep you healthy – body and mind.

This year, UTGME offers you the following health plan:

- **Medical HMO Open Access Plus**

As well as:

- **Dental Preferred Provider Organization**
- **Cigna Vision**

Your employer works with Cigna to offer you health plans that provide the coverage, tools and resources you need to help you take control of your health – and health spending.

- Ways to compare costs, look at claims, search for health care providers, and more using the myCigna® website or app.
- Use any one of the thousands of pharmacies in your network, including Cigna Home Delivery Pharmacy℠.
- Access to board-certified doctors by phone or online video through telehealth.
- Access real-time information from a nurse advocate[1] when you call our Health Information Line.
- Take steps to maintain good health with annual wellness check-ups and screenings.

At Cigna, we're here to support you on your health journey. So, you don't have to go it alone.

Health care reform: Meeting the requirements

Coverage under your employer-sponsored health plan is considered "minimum essential coverage" under the Affordable Care Act. The individual mandate was effectively repealed beginning Jan. 1, 2019, when the penalty was zeroed out; however, Americans will still need to report health coverage during the IRS tax season.[2]

Each year, Cigna, or your employer, will mail you an IRS Form 1095 confirming the coverage you were offered and any coverage you and any dependents may have had during the prior calendar year. The form should be kept with your tax records for audit purposes, and not filed with your income tax return.

Please read all of the information in this brochure. Health plans may work differently, so it's important to use this along with your other enrollment materials as a guide to how your health plans work. If you need help, talk with Meagan Sneed at 1.888.393.9500 or visit msneed@hollandinsuranceinc.com.

1. These nurse advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing medical advice in any capacity as a health advocate.
2. Health care reform information last updated in March 2019: With a permanent repeal of the individual mandate, it is possible reporting requirements may change. Please check InformedonReform.com for any updates.

Call the preenrollment hotline at 1-800-564-7642 if you have questions.

UTGME

Medical HMO Open Access Plus

The Cigna HMO plan provides coverage for medical care, including:

- Visits to your doctor's office
- Hospital stays
- Mental health and substance use services
- Chiropractic treatment, physical therapy and other services

Once you meet your deductible, you pay either a set fee (copay) and/or a percentage of the cost (coinsurance) and your health plan pays the rest. For any services that have a copay, you will pay that copay amount at the time you receive the service regardless of whether your plan deductible has been met. That copay amount doesn't apply to your plan deductible.

The amount you pay out-of-pocket is limited. Once you reach an annual limit on your payments (out-of-pocket maximum) the health plan pays your covered health care costs at 100%.

Important features:

- To receive coverage, you must select an in-network primary care provider to help guide your care and provide your routine care needs.
- Your provider will give you a referral if you need to see a specialist. You do not need a referral for OB/GYN or emergency services.
- Certain in-network preventive care services are covered at no added cost to you.
- If you see a provider who is not in-network, you will not receive coverage except in emergencies.
- No claim paperwork necessary when you receive care in-network.
- You'll receive 24-hour coverage for emergency care, in- or out-of-network.

You can view highlights of this plan on page 7. Remember, this brochure is a guide only. Make sure to read all your enrollment information thoroughly, as plan details may vary.

Cigna HMO plans are offered by Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc. (IL & IN), Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc. (MO, KS & IL), Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (TN & MS), or Cigna HealthCare of Texas, Inc.

HOW YOUR HMO PLAN WORKS

What's covered: Your medical care and prescription drugs. Certain in-network preventive care services are covered at no added cost to you.

This is how most plans work generally, but costs and coverage for specific types of services may vary under your plan.

Medical HMO Open Access Plus[2]

Medical plan highlights

	Medical deductible		Out-of-pocket maximum	
	In-network	Out-of-network	In-network[1]	Out-of-network
Employee	$400	$800	$1,600	$3,200
Employee / Spouse	$800	$1,600	$3,200	$12,100
Employee / Child	$800	$1,600	$3,200	$12,100
Family	$800	$1,600	$3,200	$12,100

Prescription medication highlights

	Retail (30-day supply)	Retail (90-day supply)	Home delivery (90-day supply)
Pharmacy deductible	Not applicable	Not applicable	Not applicable
Generic	$7.00		$21.00
Preferred brand	$25.00		$75.00
Non-preferred brand	$50.00		$150.00

Office/routine care – What you'll pay once you meet your deductible

	In-network	Out-of-network
Adult preventive care[3]	100%	not covered
PCP office visit	$25 copay	30%
Specialist visit	$45	30%
Prenatal care	$25/$45 Specialist copay	30%
Chiropractic	$25 copay	30%
Physical, occupational and speech therapy	$25 copay	30%
Well-childcare[3]	100%	30%
Lab, x-ray, diagnostic tests	100%	30%
Durable medical equipment	100%	30%

Hospital and urgent care – What you'll pay once you meet your deductible

Inpatient hospitalization	10%	30%
Outpatient surgery	10%	30%
Emergency room	$100 per visit	$100 per visit
Urgent care center	$50 per visit	$50 per visit
Ambulance	10%	10%

Mental health and substance use – What you'll pay once you meet your deductible

Inpatient (unlimited day maximum)	10%	30%
Outpatient	10%	30%

We're here for you 24/7/365

Life doesn't operate 9 to 5 – and neither should your health plan. Call us whenever you have a question or need help. We're open 24 hours a day, seven days a week, 365 days a year.

- Find a doctor, check your coverage and ask about a claim.
- Talk with a nurse advocate[1] on the phone for help finding answers to health questions, deciding the right place for care (for example, ER vs. urgent care center) and helpful home care suggestions.
- Talk with a Cigna pharmacist – 24/7 – about your medication, interactions and side effects. They can also help you find ways to lower your medication costs.
- Log into the myCigna® website or App[2] to view your ID card information, and get the details you need to make the right decisions for you and your family. The myCigna tool gives you personalized search results via the website or app to help you easily find the right doctors and health care facilities.

1. These nurse advocates hold current nursing licensure in a minimum of one state but are not practicing nursing or providing medical advice in any capacity as a health advocate.
2. Actual myCigna features will vary depending on your plan and individual security profile.

1. This is the most a family (employees plus covered family members) will pay for in-network out-of-pocket expenses. It's important to note that each individual family member's out-of-pocket costs are capped at $8,150 for 2020 health plans, overall family in-network costs are capped at $13,800. The out-of-pocket costs for people with individual coverage are capped at $6,900. To see examples of how this works, please visit www.InformedOnReform.com > Reform Topics Overview > Cost Sharing Limits, or Cigna.com/health-care-reform/embedded-oop-customer-impacts.
2. What you'll pay after you meet your deductible. You'll pay 100% of the cost until you meet your deductible.
3. Certain in-network preventive care services and well-childcare services are covered at no added cost to you. You have no deductible to meet for these services.

The information in this brochure is provided as a guide only. Make sure to read all your enrollment information thoroughly, as plan details may vary. If you need more assistance, talk to Meagan Sneed at 1.888.393.9500 or send an email to msneed@hollandinsuranceinc.com.

Health plans provide coverage for most medically necessary services. However, there are certain services and supplies that may not be covered. See the "What's Not Covered" section of this guide for examples of plan exclusions.

Dental Preferred Provider Organization (DPPO)

The DPPO plan provides coverage for dental care, including visits to your dentist for regular oral exams, including cancer screenings, cleanings, fluoride treatments and x-rays.[1]

You have the freedom to see any licensed dentist. You can even choose a different dentist each time you need care. But keep in mind that you can save money when you visit a dentist in the Cigna DPPO network.

With the DPPO plan, you'll typically pay an annual amount (deductible) before your plan begins to pay for a portion of covered dental care costs. You may also have a waiting period for some services – which is the amount of time that must pass before these services are covered.

Once you meet your deductible and satisfy any waiting periods, you'll pay a portion of your covered dental care costs (coinsurance). Your plan pays for the rest, up to your plan's calendar year benefit maximum.

Cigna DPPO network dentists will submit claims for you, and your plan will pay the dentist. You can also pay the full amount to the dentist's office, then submit a claim and ask to be reimbursed for covered charges.

Your plan also has a calendar year benefit maximum. Once you reach that maximum, your plan will no longer pay a portion of your costs during that plan year. However, dentists in Cigna's DPPO network may still offer you discounts on certain services.[2]

Important features:

- No referral is needed to see a dental specialist.
- Certain preventive services may be covered at little or no extra cost to you when you visit a dentist in Cigna's DPPO network.
- You do not need an ID card to receive care. But, if you want to, you can print one from **myCigna.com** after you enroll in a DPPO plan.

Remember, this brochure is a guide only. The details of your plan may vary. Make sure to read your enrollment materials for details of your specific dental plan.

1. In general, the following frequency limitations apply: Two (2) exams and cleanings per calendar year; two (2) fluoride treatments per calendar year for people under age 16; one (1) bitewing x-ray per calendar year; one (1) full mouth x-ray every five (5) calendar years; one (1) panorex x-ray every five (5) calendar years. Plans may vary, so review your plan documents for a complete list of covered and non-covered services.
2. Discounts on non-covered services may not be available in all states.

Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries.

How your DPPO plan works: What you'll pay once you meet your deductible

Plan details	DPPO Plan in-network	DPPO Plan out-of-network[3]
Deductible (individual/family)	$50/$150	$50/$150
Class I (preventive)	100%	100%
Class II (basic)	80%	80%
Class III (major)	50%	50%
Class IV (orthodontic)	$0	$0
Annual year maximum	$1,000	$1,000
Orthodontic lifetime maximum	$0	$0

In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.
Please review your Benefit Summary for details, including plan exclusions and limitations.

3. Out-of-network charges are subject to the plans' Maximum Allowable Charge provisions.

Vision

Vision plans provide access to one of the largest specialty networks of quality eye care[1] – from private practice eye doctors to nationally recognized retail optical stores.

When you choose one of the eye doctors in the Cigna Vision network, you'll get the most savings for covered services. You can also choose to see an eye doctor who is out of the network; however, you'll have to pay the full cost of the service at the time of the appointment. Then you'll need to submit a claim form to get reimbursed for covered charges.[2] Whether you choose a doctor in or out of our network, you'll also be responsible for paying any charges that aren't covered by your plan.

In addition to your vision plan coverage, check with your eye doctor to see if he or she participates in the Healthy Rewards® Vision Network Savings Program. This program is available to all Cigna Vision customers, and you can save 20% or more on additional eyeglass frames and/or lenses with a valid prescription.[3]

Important features:

- The Cigna Vision network is different from the networks supporting our health plans. You can choose your own eye doctor, but you'll save money when you stay in the Cigna Vision network.
- You pay your plan copay(s), any amount over the plan allowances and costs for non-covered services.
- No claim paperwork necessary when you receive care in-network.
- You may find additional savings if your eye doctor participates in the Healthy Rewards Vision Network Savings Program.

Remember, this brochure is a guide only. Make sure to read your benefit summary for details of your specific vision plans. Plan details may vary.

1. Competitive landscape based on publicly available industry numbers found on company websites as of December 2017. Subject to change.
2. Your Cigna Vision plan coverage is based on the plan chosen by your employer. Be sure to review your plan benefit summary for details on covered and non-covered services. Plan deductibles, coinsurance, copays and materials allowances may apply.
3. Discount is based on retail prices. **Healthy Rewards is a discount program and is NOT insurance.** You are required to pay the entire discounted charge.

Vision plans are insured and/or administered by Cigna Health and Life Insurance Company or Connecticut General Life Insurance Company.

How your Cigna Vision PPO Comprehensive (C1) plan works:

Plan details for in-network coverage	
Exam copay	$10.00
Materials copay	$20.00
Frame retail allowance	up to $130.00
Elective contact lenses and professional services retail allowance	up to $130.00

Please review your Benefit Summary for details, including plan exclusions and limitations.

At Cigna, we're committed to making it easier for you to take control of your health – and your health care costs.

Here are a few easy ways you can save on out-of-pocket health care expenses if you enroll in a health plan.

Stay in-network.

Save big when you use a doctor, hospital or facility that's part of your plan's network. Chances are, there's a network doctor or facility right in your neighborhood. It's easy to find quality, cost-effective care right where you need it.

Consider using an urgent care center.

If you need medical attention, but it's not serious or life-threatening, you may not have to go to an emergency room (ER). An urgent care center provides quality care like you'd get in the ER, but also provides lower costs, shorter wait times and extended hours. An urgent care center can treat things like minor cuts, burns and sprains, fever and flu symptoms or lower back pain.

Consider using a convenience care clinic.

Sinus infection. Rash. Earache. Minor burns. When you need face-to-face routine medical care but can't wait for an appointment, consider using a convenience care clinic. You'll get quick access to quality and affordable medical care. A convenience care clinician can treat you for a range of routine medical conditions and immunizations. You can find convenience care clinics in grocery stores, pharmacies and other retail stores.

You can use telehealth for 24/7 care.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions (if appropriate) – for a wide range of minor conditions. You can connect with a board-certified provider via video chat or phone, when, where and how it works best for you.

Choose when: 24/7/365 Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Prescriptions are not guaranteed to be written and telehealth may not be available in all areas or with all providers. Video chat may not be available in all areas or with all providers. Providers are solely responsible for any treatment provided to their patients. See your enrollment materials for details.

Know before you go.

Here's an at-a-glance view of your options when you need medical care.

	Cost	Wait time	Severity
Cigna Telehealth Connection	$		
Convenience care clinic	$$		
Primary care provider	$$$		
Urgent care center	$$$		
Emergency room	$$$$		

* For illustrative purposes only. Actual costs and wait times will vary. Always consult with your doctor for medical advice, including prior to selecting another provider for care.

Stick with lower-cost labs.

If you go to a national lab, such as Quest Diagnostics® or Laboratory Corporation of America (LabCorp®), you can get the same quality service and save up to 70%. Even though other labs may be part of the Cigna network, you'll often get even bigger savings when you go to a national lab. And with hundreds of locations nationwide, they make it easy to get lab services at a lower cost. *(Savings estimate is based on national 2018 averages of participating facilities. Savings will vary.)*

Visit independent radiology centers.

If you need a CT scan or MRI, you could save hundreds of dollars by using an independent radiology center. These centers can provide you with quality service like you'd get at a hospital, but usually at a lower price.

Choose the right place for your colonoscopy, endoscopy or arthroscopy.

When you choose to have one of these procedures at an in-network freestanding outpatient surgery center, you could save hundreds of dollars. These facilities specialize in certain types of outpatient procedures, and offer quality care, just like a hospital, but at a lower cost to you.

This information is for educational purposes only. It is not medical advice. Always consult your doctor for examinations, treatment, testing and care recommendations. In an emergency, dial 911 or visit the nearest emergency room.

Prescription medication coverage.

Your plan's drug list.

The Cigna Prescription Drug List is a list of the generic and brand medications your plan covers. You can search for a specific medication or view your plan's drug list on **myCigna.com**.[1]

Your pharmacy network.

There are thousands of retail pharmacies in your network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop. If your plan allows, you can use Cigna Home Delivery Pharmacy to fill your prescriptions.[2]

Every pharmacy in your network can fill 30-day prescriptions, and a select number of pharmacies can fill 90-day prescriptions. To find a pharmacy in your network that's approved to fill 90-day supplies, go to Cigna.com/Rx90network.

Most plans require you to fill your prescriptions at an in-network pharmacy to receive coverage. If you fill a prescription at a pharmacy that's not in your plan's network, your plan may not cover the medication or you may pay more out-of-pocket. You should check your plan materials to learn more about your out-of-network coverage.

The money you spend on your prescription medications goes toward your plan's annual deductible. This includes the prescriptions you fill at your local in-network retail pharmacy and/or through Cigna Home Delivery Pharmacy, as well as pharmacies that aren't in your network.

Use the pharmacy tools and resources on the myCigna® App or website to learn more about your pharmacy benefits. Online, 24/7.

Avoid surprises at the pharmacy.

- Price a medication and search for lower-cost alternatives, if available[4]
- See which medications your plan covers
- Ask a pharmacist a question

Stay organized.

- See your pharmacy claims
- Update your personal profile
- Set up your communication preferences

Cigna Home Delivery Pharmacy.[3]

- Sign up for auto refill, if available
- Request a refill
- Check your order status and track shipments
- View your order and medication histories

1. Please refer to your phone's manufacturer for your phone's specific capabilities. The downloading and use of the myCigna app is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply. Actual myCigna features may vary depending on your plan and individual security profile.
2. You may be taking a medication that isn't actually available in a 90-day supply. Certain medications may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply", it's still considered a 90-day prescription.
3. Not all plans are the same, so some plans may not include Cigna Home Delivery Pharmacy. Please log in to the mycigna App or website, or check your plan materials, to learn more about the pharmacies in your plan's network.
4. Prices are not guaranteed, and even though a price is displayed, it's not a guarantee of coverage. Your costs and coverage may change by the time you fill your prescription at the pharmacy, and medication costs at individual pharmacies can vary. For example, your pharmacy's retail cash price for a specific medication may be less than the price shown. Coverage and pricing may change. See your plan documents for cost and coverage details.

24/7 customer assistance.

Anytime you need us, feel free to call the toll-free number printed on the back of your Cigna ID card.

- You can reach us 24 hours a day, seven days a week.
- You can get answers to your health, claims and benefit questions.
- Ask for a Spanish-speaking service representative or someone who can translate one of 200 languages.
- You can order an ID card, update insurance information and check claim status.

24/7 customer assistance is available for medical and dental plan customers only.

Make myCigna your Cigna.

Nothing is more important than your good health. That's why there's **myCigna** – your online home for assessment tools, plan management, medical updates and much more.

On **myCigna** you can:

- Find in-network doctors and medical services
- View ID card information
- Review your coverage

- See how much your medication will cost you at the different pharmacies in your network.[1]
- Manage and track claims
- Order refills or talk with a pharmacist at Cigna Home Delivery Pharmacy℠[2]
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Sign up to receive alerts when new plan documents are available
- Track your account balances and deductibles

Download the myCigna App and access your account with just a fingerprint on any compatible device.[3]

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2. Not all plans are the same, so some plans may not include Cigna Home Delivery Pharmacy. Please log in to the myCigna App or website, or check your plan materials, to learn more about the pharmacies in your plan's network.
3. Please refer to your phone's manufacturer for your phone's specific capabilities. The downloading and use of the myCigna app is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply. Actual myCigna features may vary depending on your plan and individual security profile.

Healthy Awards Account.

When you complete specific health and wellness programs, you'll receive a contribution to your Healthy Awards Account. The money in your account can be used to pay for certain covered health care expenses. Money in your account rolls over into the next plan year. If you ever needed a reason to begin healthy habits, here it is.

Cigna Healthy Pregnancies, Healthy Babies Program.

Each woman's journey to motherhood is unique. Enrolling in the Cigna Healthy Pregnancies, Healthy Babies® program is a healthy place to start.

To support you along your journey, you'll get:

- Helpful guidance and support on everything from infertility and preconception planning to post-delivery information.
- A workbook to help you learn about pregnancy and babies, including topics like prenatal care, exercise, stress, depression and more.
- 24/7 live telephone support from a case manager, who has nursing experience and can help you with everything from tips on how to handle your discomfort during pregnancy to birthing classes and maternity benefits.
- Access to an audio library of health topics.
- Incentives for participating in the program, if offered by your employer.

You'll also have easy access to a wealth of information on the **myCigna**® website from trusted sources like WebMD and Healthwise. You'll learn how to make a plan for a healthy pregnancy, monitor your pregnancy week by week, prepare for labor and delivery, care for your baby and more.

Cigna Veteran Support Line.

This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer. Cigna stands ready to connect you with:

- Pain management resources
- Substance use counseling
- Financial support
- Food, clothing, housing
- Legal assistance
- Parenting and child care
- Aging services
- Weekly Mindfulness for Vets phone sessions and more

Call **855.244.6211**.

What's not covered[1]

Your benefit plan pays for health services that may help you stay well, treat illness or manage medical conditions, but all plans have exclusions and limitations. Following are examples of some services not covered by your employer's medical plan, unless required by law.

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit, including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Custodial and other non-skilled services
- Weight-loss programs
- Hearing aids
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Acupuncture
- Infertility services
- Obesity surgery and services
- Eyeglass lenses and frames, contact lenses and surgical vision correction
- If your employer offers prescription drug coverage through Cigna, Your plan doesn't cover all medications. For example, over-the-counter medicines (which are available without a prescription) and weight loss medications are typically not covered. Not all plans are the same, but, in general, to be eligible for coverage, a medication must be approved by the U.S. Food and Drug Administration (FDA), prescribed by a health care provider, purchased from a licensed pharmacy and medically necessary. If your plan covers certain prescription medications at no cost-share to you, your plan may require you to use an in-network pharmacy to fill the prescription. If you use a pharmacy that isn't in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copay, coinsurance or deductible requirements.

These services may not be covered under your medical plan. However, you may be able to pay for them using your health account (for example HRA, HSA or FSA) if you have one, if permitted under applicable federal tax regulations.

1. This is a summary only and your plan's actual terms may vary. For a complete list of both covered and not-covered services, including benefits required by your state, please see your employer's insurance certificate or summary plan description – the official plan document. If there are any differences between the information in this brochure and the plan document, the information in the plan document takes precedence.

Discrimination is against the law

Medical coverage

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. 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
800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

Polish – UWAGA: w celu skorzystania z dost pnej, bezpłatnej pomocy j zykowej, obecni klienci firmy Cigna mog dzwoni pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

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

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

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

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

Here is important information you should read before you enroll. If you have any questions about this information, please contact Meagan Sneed at 1.888.393.9500 or send an email to msneed@hollandinsuranceinc.com.

If you are declining enrollment.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the other coverage is COBRA continuation coverage, you and your dependents must complete your entire COBRA coverage period before you can enroll in this plan, even if your former employer ceases contributions toward the COBRA coverage.

In addition, 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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 or later, if you or your dependents lose eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for assistance with group health plan premium payment under a state Medicaid or CHIP plan, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the state Medicaid or CHIP coverage ends or you are determined eligible for premium assistance.To request special enrollment or obtain more information, call our Customer Service Team at 800.Cigna24 (800.244.6224).

To request special enrollment or obtain more information, call our Customer Service Team at 800.Cigna24 (800.244.6224).

Other late entrants.

If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your health plan. Please contact your plan administrator for more information.

Women's Health and Cancer Rights Act (WHCRA).

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
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan as shown in the Summary of Benefits. If you would like more information on WHCRA benefits, call our Customer Service Team at 800.Cigna24 (800.244.6224).

Your enrollment checklist

Please send in your enrollment choice by 06/30/2020.

This is one of the most important decisions you'll make this year. These steps will help you choose wisely.

- ✓ If you need help or have questions, please contact Meagan Sneed with Holland Insurance at 662-895-5528 or email msneed@hollandinsuranceinc.com
- ✓ Check the online directory on **Cigna.com** to see if your doctor participates in our network.
- ✓ Review your Summary of Benefits for specific plan details.
- ✓ Visit **www.bernieportal.com/en/login** to review benefit details and enroll. Please see page 43 for full instructions.

UTGME CIGNA MEDICAL, DENTAL & VISION MONTHLY RATES

EMPLOYEE	$100.00
EMPLOYEE & SPOUSE	$200.00
EMPLOYEE & CHILDREN	$180.00
FAMILY	$280.00

Call the preenrollment hotline at 1-800-564-7642 if you have questions.

The information in this brochure is provided as a guide only. Make sure to read all your enrollment information thoroughly as plan details may vary. If you need more assistance, talk with your Human Resources representative.

Dentists that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

The health care provider information we include in this guide and through Cigna websites is for educational purposes only. It is not a guarantee of the quality of care that will be provided to individual patients. You are encouraged to consider all relevant factors and consult with your physician when selecting a health care provider. The providers that participate in Cigna's networks and available through the Cigna Telehealth Connection program (if offered with your plan) are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group insurance policies and group benefit plans may contain exclusions, limitations, reduction of benefits, and terms under which the policies or plans may be continued in force or discontinued. For costs and complete details of coverage, see your plan documents.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC. In Texas, Open Access Plus and LocalPlus® plans are considered Preferred Provider Plans with certain managed care features, and Open Access Plus In-Network and LocalPlus IN plans are considered Exclusive Provider plans with certain managed care features. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.

UTGME20 SR#:

Personal guidance for better health and savings.

Cigna One Guide® personal guides can help you make informed choices and get the most from your plan. It's our highest level of support that combines the personal touch of live service with tools and resources you can access through the web, an app or an online chat feature.

During enrollment, a Cigna One Guide representative is just a call away to help you.

- Easily understand the basics of health coverage.
- Identify the types of health plans available to you to help you choose the one that best meets the needs of you and your family.
- Check if your doctors are in-network to help you avoid unnecessary costs.
- Get answers on any other questions you may have about the plans or provider networks available to you.

After enrollment, the support continues with personalized assistance to help you:

- Resolve health care issues.
- Save time and money.
- Get the most out of your plan.
- Find the right hospitals, and other health care providers in your plan's network.
- Get cost estimates.
- Understand your bills.
- Navigate the health care system.

Get it all in the way that's most convenient for you.

- Call **888.806.5042**.
- Once you have enrolled, start using Cigna One Guide support by registering on myCigna web or app,* click to chat or by phone.

DON'T WAIT UNTIL THE LAST MINUTE.

Call 888.806.5042 to speak with a One Guide representative today.

Together, all the way.®

Cigna®

SUMMARY OF BENEFITS

Cigna HealthCare of Tennessee, Inc. and Connecticut General Life Insurance Co.
For - University of Tennessee Graduate Medical Education Program
HMO POS Open Access Plan
TN POSOA
Effective - 07/01/2020

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
Coinsurance	Your plan pays 90%	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable	110%
Contract Year Deductible	Individual: $400 Family: $800	Individual: $800 Family: $1,600

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. The amount you pay for out-of-network covered expenses only counts towards your out-of-network deductible.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

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

Contract Year Out-of-Pocket Maximum	Individual: $1,600 Family: $3,200	Individual: $6,050 Family: $12,100

- Only the amount you pay for in-network covered expenses counts towards your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network 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.
- In-Network covered expenses that count towards your out-of-pocket maximum include the plan deductible, member paid coinsurance and copays.
- Out-of-Network covered expenses that count towards your out-of-pocket maximum include the plan deductible, member paid coinsurance and benefit deductibles. Non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- 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 (^).		
Physician Services		
Physician Office Visit • Plan pays 100% after you pay copay	$25 Primary Care Physician (PCP) copay or $45 Specialist copay	Your plan pays 70% ^
Surgery Performed in Physician's Office	$25 PCP or $45 Specialist copay	Your plan pays 70% ^
Allergy Treatment/Injections	$25 PCP or $45 Specialist copay or actual charge (if less)	Your plan pays 70% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 70% ^
Cigna Telehealth Connection Services	$25 copay	Not Covered
• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com) • Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.		
Preventive Care		
Preventive Care	Your plan pays 100%	Not Covered
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations	Your plan pays 100%	Not Covered
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 70% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Associated wellness exam is covered in-network only. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		
Inpatient Hospital Facility	Your plan pays 90% ^	Your plan pays 70% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 90% ^	Your plan pays 70% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^	Your plan pays 70% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
Outpatient		
Outpatient Facility Services	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 90% ^	Your plan pays 70% ^
Short-Term Rehabilitation	$25 copay	Your plan pays 70% ^
Contract Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care (In-network only) – 60 days in-network and 20 days out-of-network • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. • In-Network days count towards both In-Network and Out-of-Network Maximums		
Cardiac Rehabilitation	$45 Specialist copay	Your plan pays 70% ^
Contract Year Maximums: • Cardiac Rehabilitation - 36 days Note: • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. • In-Network days count towards both In-Network and Out-of-Network Maximums		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • 60 days maximum in-network per Contract Year and 40 days maximum out-of-network per Contract Year. Maximums cross-accumulate. (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day	Your plan pays 100% after Home Health Care Deductible is met	Your plan pays 70% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Contract Year	Your plan pays 90% ^	Your plan pays 70% ^
Durable Medical Equipment • Unlimited maximum per Contract Year for in-network only	Your plan pays 100%	Not Covered
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	Your plan pays 100%	Not Covered

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^).		
External Prosthetic Appliances (EPA) • $200 EPA annual deductible • Unlimited maximum per Contract Year	Your plan pays 100%	Not Covered
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
Hearing Aid • Maximum of 2 devices (one per ear) per 3 Years • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share. • Coverage through age 17	Your plan pays 100%	Your plan pays 100%, up to Unlimited per device

Place of Service - your plan pays based on where you receive services

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

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%		Plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 70% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc. Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit								

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$100 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 90% ^	
Urgent Care	$50 per visit (copay waived if admitted)		Plan pays 100%		Not Applicable	
*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.						

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 90% ^	Not Covered	Plan pays 100%	Not Covered
Bereavement Counseling	Plan pays 90% ^	Not Covered	Plan pays 100%	Not Covered
Note: Services provided as part of Hospice Care Program				

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	$25 PCP or $45 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	$25 PCP or $45 Specialist copay	Plan pays 70% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Non-elective procedures)	$25 PCP or $45 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Family Planning - Men's Services	$25 PCP or $45 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility **Note:** 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.										
TMJ, Surgical and Non-Surgical	$25 PCP or $45 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										

Benefit	Inpatient Hospital Facility		Inpatient Professional Services	
	Cigna LifeSOURCE Transplant Network® Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network® Facility In-Network	Out-of-Network
Organ Transplants	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered
Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility: Unlimited • Bone marrow transplants for the treatment of cancer are covered out-of-network				
Note: Services where plan deductible applies are noted with a caret (^).				

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 90% ^	Plan pays 70% ^	$25 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Substance Use Disorder	Plan pays 90% ^	Plan pays 70% ^	$25 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Note: Services where plan deductible applies are noted with a caret (^).						

Note:

- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Plus Cost Share • Retail – up to 30-day supply • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)	**Retail (per 30-day supply):** Generic: You pay $7 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $50 **Home Delivery (per 90-day supply):** Generic: You pay $21 Preferred Brand: You pay $75 Non-Preferred Brand: You pay $150

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.

Drugs Covered

Prescription Drug List:
Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential

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

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

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester)

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 Contract 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 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

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

Multiple Surgical Reduction
In-Network - does not apply.
Out-of-Network - Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

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.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 20% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

7/1/2020
TN
HMO Point of Service - TN POSOA

Additional Information

Pre-Certification - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 20% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

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.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

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

Exclusions

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a Provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to reduce the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received, excluding nongovernmental charitable research hospitals.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
    - In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication for charges for a drug prescribed for treatment of life-threatening illnesses such as cancer, AIDs and coronary heart disease solely because the drug has not received FDA approval for that specific type of condition. A drug must be recognized as safe and effective for treatment of that specific type of condition in any of the standard reference compendia (American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information) or in medical literature will not be denied. A claim would not be denied solely on the basis that the person was a participant in a clinical trial.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy;

Exclusions

dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics and casts. However, coverage is provided for charges for anesthesia, Hospital and Physician expenses for inpatient or outpatient Hospital Dental procedures when performed on a child 8 years of age or younger when the procedure cannot safely be performed in a dental office. Charges made for services or supplies provided for or in connection with an accidental injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following surgical procedures are covered: TMJ, CMJ, jaw surgery, excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.

Exclusions

- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism except for special dietary formulas that are Medically Necessary for the therapeutic treatment of PKU (phenylketonuria).
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- E-mail, and internet consultations.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, the fetus is not viable, or the expenses are incurred to treat medical complications due to abortion. Abortions for Plans utilizing state funds are not excluded when pregnancy is the result of an act of rape or incest.

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.

EHB State: TN

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

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

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. 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
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cigna Dental Benefit Summary
UT Graduate Medical Education Program - DPPO
Plan Renewal Date: 07/01/2020

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Out-of-Network:*** **Non-Network**	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
Policy Year Benefits Maximum Applies to: Class II and III expenses	$1,000		$1,000	
Policy Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: bitewing X-rays: full mouth X-rays: panoramic X-rays: periapical Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Emergency Care to Relieve Pain Restoration: fillings Oral Surgery: simple extractions	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
Class III Benefit Waiting Period applies for 12 months.				
Class III: Major Restorative Periodontal Maintenance Anesthesia: general and IV sedation Endodontics: root canal therapy Periodontics: periodontal scaling & root planing Periodontics: osseous surgery Oral Surgery: oral surgical procedures Oral Surgery: extractions of impacted teeth Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments Inlays and Onlays Stainless Steel and Resin Crowns Crowns, Bridges and Dentures Prosthesis Over Implant	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Policy Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Policy Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Benefit Waiting Period	No benefits will be paid for charges that are incurred during any applicable Benefit Waiting Period.
Late Entrant Limitation Provision	No coverage until the next open enrollment period. This provision does not apply to new hires.

Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $500 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the plan deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation Provision	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 24 months; thereafter, considered a Class III expense.
Oral Evaluations	1 per 6 consecutive months
X-rays: bitewing	1 set per 12 consecutive months, limited to 4 films per set
X-rays: full mouth or panoramic	1 per 60 consecutive months
X-rays: periapical	4 per 12 consecutive months if not in conjunction with an operative procedure
X-rays: Intraoral occlusal	2 per 12 consecutive months
Cleaning: routine	1 prophylaxis (Class I) or periodontal maintenance (Class III) per 6 consecutive months
Fluoride Application	1 per 12 consecutive months for children under age 14
Sealants: per tooth	1 treatment per lifetime for children under age 14; payable on unrestored permanent bicuspid or molar teeth only
Space Maintainers	Limited to non-orthodontic treatment for children under age 14
Restoration: fillings	1 per 12 consecutive months; applies to replacement of identical surface fillings only, no composite, white/tooth colored fillings on bicuspid or molar teeth
Inlays and Crowns	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges. Replacement must be indicated by major decay. For people under age 16, benefits for crowns and inlays are limited to resin or stainless steel.
Stainless Steel and Resin Crowns	1 per 36 consecutive months for children under age 16
Endodontic Treatment	Root canal retreatment 1 per 24 consecutive months, based on necessity
Periodontal Scaling and Root Planning	1 per quadrant per 36 consecutive months
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired
Denture Adjustments	Covered if more than 12 consecutive months after installation; 1 per 12 consecutive months
Denture Repairs	Covered if more than 12 consecutive months after installation
Denture Rebases and Relines	Covered if more than 12 consecutive months after installation; 1 per 36 consecutive months
Prosthesis Over Implant	1 per 84 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: core buildup; veneers; precious or semi-precious metals for crowns, bridges, pontics and abutments; restoration of teeth which have been damaged by erosion, attrition or abrasion; Periodontics: bite registrations; splinting;	
Prosthodontics: overdentures; precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services; Orthodontics: orthodontic treatment;	
Anesthesia: general anesthesia or intravenous sedation, when used for the purposes of anxiety control or patient management is not covered; may be considered only when medically or dentally necessary and when in conjunction with covered complex oral surgery; Drugs: prescription drugs;	
Procedures, appliances or restorations, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	

Services that are deemed to be medical in nature; services and supplies received from a hospital;
Charges in excess of the Maximum Allowable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
UT Graduate Medical Education Program
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit*** **	**Out-of-Network Benefit**	**Frequency Period ** **
Exam Copay	$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $130	Up to $71	24 months
** Your Frequency Period begins on the 1st of your plan renewal month (Contract year basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes***:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.
*** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com,"Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna

Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• 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.

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under the UTGME group health plan(s), collectively known as the "Plan." This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

<BANKRUPTCY>

When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee<RETIREES> or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide written notice to:

Holland Insurance, Inc.
PO Box 328
Southaven, MS 38671

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month on continuation coverage and sent to:

Holland Insurance, Inc.
PO Box 328
Southaven, MS 38671

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse

and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Plan Administrator:
Holland Insurance, Inc.
PO Box 328
Southaven, MS 38671
662-895-5528

UTHSC

GRADUATE MEDICAL EDUCATION

All Residents will enroll for their benefits through our online enrollment site "Bernieportal". Please follow the instructions below.

Below are the instructions for how to login and enroll or waive your CIGNA benefits

Go to: https://www.bernieportal.com/en/login

Employee default logins:
Username: email address
Password: last 4 digits of SSN + 2 digit birth month

Dear Cigna Healthcare Member:

Enclosed is your temporary Group Benefits Identification Card. This ID card should be used for your benefit plan effective date 7/1/2020. Present this temporary ID card to your provider or pharmacist on your next visit.

If you have Internet access and a printer, a copy of your permanent ID card should be available. Please visit www.myCigna.com and create a user-name and password to gain access to this temporary card.

You may also download the myCigna mobile app on your smart phone to have access to your card on your phone.

When you receive your permanent Cigna id card in the mail, please destroy this temporary ID card and replace it with the permanent card(s).

This temporary ID Card should be safeguarded in the same way you protect credit cards. The information contained on the card regarding your benefit plan should only be shared with healthcare providers and others properly requiring this information for claim submission.

Thank you for your cooperation.

Medical Temporary ID Card
UTGMEP

Account #: 3313068

POS Open Access

PCP: $25 Copay Spec Visit: $45 Copay ER: $100 Copay Urgent Care: $50 Copay Rx Copay: $7/$25/$50
In-Network: 90% after Deductible
Out of Network: 70% after Deductible

Claim or coverage inquiry: 1-800-244-6224
Effective Date : 07/01/2020

RxBin: 017010 Rx PCN: 0215COMM
Rx Group: 3313068

Cigna.

Customer Support Number:
800. 244.6224
(24 hours a day, 365 days a year)

Send Medical Claims To:
CIGNA
PO Box 182223
Chattanooga, TN 37422-7223

You may be asked to present this card when you access care. This card doesn't guarantee coverage. You must comply with all items and conditions of the plan. Willful misuse of this card is considered fraud.
Hospital Admission: Prior to any non-emergency hospital admission, you or your doctor must call the toll-free Cigna Customer Support number shown below to request "precertification". In the case of an emergency, you, your family, or your doctor must call within 24 hours of hospital admission. Failure to contact Cigna will affect your coverage.
In an Emergency: Seek care immediately. Go directly to the nearest emergency facility or call 911.