Health Benefits Guide

2023-2024

Town of Centreville

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Welcome to Your Health Benefits Guide

Town of Centreville Local Government ("Town") takes pride in offering a comprehensive and competitive benefits package to our employees. The Town, through all of our benefits partners, offers you a benefits program that allows choice and flexibility. Through this guide, you can select benefits that work best for you and your family.

2023-2024 Plan Year

- Benefits will be effective for the July 1, 2023 – June 30, 2024 plan year.

- The Town continues to evaluate ways to improve the quality of your healthcare and keep our health plans competitively priced, while controlling costs for you and the Town. We encourage staff to become and remain engaged in these efforts by being educated on the plans and using them wisely. Be sure to participate in Employee Wellness programs and activities, and partner with your physician to get appropriate preventive screenings. Also, consider programs like mail order pharmacy and generic prescriptions to lower your copays and overall plan costs.

- When reviewing your benefits, please be aware of the difference between the following terms:
    - Calendar Year – runs from January 1 to December 31 and resets each January 1.
    - Plan Year – Town benefit plan year, which runs from July 1 to June 30.
    - Every 12 months – a rolling 12 months that begins on the date of your most recent service.

It is important to take time to review the plan options available to you prior to making your selections. Consider each benefit and the associated costs carefully and choose the benefits package that will meet yours and your family's needs throughout the year.

For details about each specific plan, review the sections in this guide or refer to the Helpful Contact section for contact information for each of the plans. OR Email Human Resources: kebaugh@townofcentreville.org for a copy of the specific plan document you are requesting.

THIS GUIDE IS NOT A CONTRACT

This guide is a summary of general benefits available to Town of Centreville employees and retirees and describes the highlights of our benefits in non-technical language. Our specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in this guide and the official plan documents, the language of the official document shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information. Any plan benefits may be modified in the future to meet Internal Revenue Service rules as decided by the Town.

What's New July 1

- New and improved Town's Summary of Benefits format and will now be identified as the Health Benefits Guide! Use the Table of Contents to search for topics that interest you.

- Healthcare Flexible Spending maximum annual contribution is now **$2,850**, with a **$550** carry-over

- The following carriers have changed their company name, but have not changed their services. Please note the changes below:

PLAN	FROM	TO
Flexible Spending Accounts	Innovative Health Services	CareFlex
457(b) Deferred Compensation	ICMA-RC	Mission Square
457(b) Deferred Compensation	VALIC (AIG)	Corebridge Financial

- Check out page 10 of this guide for health plan costs beginning July 1.

Benefits Eligibility

Employee Eligibility

All Town employees, as defined by Town of Centreville, are benefits eligible (full-time and permanent part-time).

Dependent Eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse, dependent children and disabled adult child. The Dependent Eligibility Documentation Requirements are outlined on page 8 of this guide.

The Town of Centreville provides a generous benefit package to eligible employees with benefit options from healthcare to income protection. The following chart outlines your benefit options for plan year:

July 1, 2023 – June 30, 2024

Benefit Options			
Plan	**Options**	**Coverage**	**Who Is Eligible***
Medical and Pharmacy	Cigna Choice Fund Open Access Plus In-Network	Begins the 1st day that all eligibility requirements are met if enrolling. Coverage ends on the last day of employment or the date that the employee is no longer eligible.	Regular Full-time employees working at least 40 hours per week. Regular Part-time employees working at least 20 hours per week.
Dental	MetLife	Begins the 1st day that all eligibility requirements are met if enrolling. Coverage ends on the last day of employment or the date that the employee is no longer eligible.	Regular Full-time employees working at least 40 hours per week. Regular Part-time employees working at least 20 hours per week.
Vision	National Vision Administration, LLC (NVA)	Begins the 1st day that all eligibility requirements are met if enrolling. Coverage ends on the last day of employment or the date that the employee is no longer eligible.	Regular Full-time employees working at least 40 hours per week. Regular Part-time employees working at least 20 hours per week.

Group Life and AD&D Insurance	Lincoln Financial Group	Begins the 1st day that all eligibility requirements are met if enrolling. Coverage ends on the last day of employment or the date that the employee is no longer eligible.	Regular Full-time employees working at least 40 hours per week.
Voluntary Life Insurance	Lincoln Financial Group	Begins the 1st day that all eligibility requirements are met if enrolling. Coverage ends on the last day of employment. Continuing coverage may be available. Contact Lincoln Finance for more information of continuing coverage.	Regular Full-time employees working at least 40 hours per week.
Flexible Spending Accounts	CareFlex	Begins the 1st day of the next month following your date of hire.	Active employees working 30 or more hours per week or 130 hours per month and eligible for the group health plan.
Accident, Cancer, Hospital, Critical Care	AFLAC	Begins in the pay cycle following enrollment and confirmation of deduction by AFLAC Rep.	Active employees
457 (b) Deferred Compensation	Corebridge Financial OR Mission Square	Begins in the pay cycle following enrollment and confirmation of deduction by Def Comp Rep.	Active employee or independent contractor of the Town.

**To be eligible, you must meet the eligibility requirements as outlined in the Eligibility section of this guide.*

When to Enroll

NEW HIRE ELIGIBILITY*	QUALIFYING LIFE EVENTS	OPEN ENROLLMENT
As a newly hired benefits-eligible employee, you are offered an initial enrollment period to elect benefits. Elections made as a new hire will stay in effect for the entire plan year and cannot be changed until the next plan year during Open Enrollment or within 30 calendar days following a qualifying life event.	Certain events in your life (i.e., marriage, divorce, gain or loss of coverage due to a job change, etc.) allow you to make changes to your benefit plan(s). If you experience a qualifying life event during the plan year, you must contact HR to make changes **within 30 calendar days** following the qualifying event date, <u>even if the supporting documentation is not yet available.</u>	You must contact HR during Open Enrollment to make any **coverage changes** for the following year. Open Enrollment is offered annually to give you the opportunity to change, elect or cancel benefits. It usually occurs in May of each year.
EFFECTIVE DATE	EFFECTIVE DATE	EFFECTIVE DATE
Date of hire.	Date of qualifying event.	Open Enrollment elections will become effective July 1 of the next plan year.

**Town requests that all benefits-eligible employees contact Human Resources to elect or decline benefits.*

How to Enroll

This chart outlines how you enroll and the deadline for enrollment for each benefit. The Town is working diligently to provide employees the ability to enroll and make benefit change requests online.

BENEFIT	HOW TO ENROLL			DEADLINE TO ENROLL	
	ONLINE	PAPER	AUTO ENROLLED	WITHIN 14 CALENDAR DAYS OF NEW HIRE DATE OR WITHIN 30 DAYS OF A QUALIFYING LIFE EVENT	NO DEADLINE
Health (Medical, Rx, Dental, Vision)		X		X	
Healthcare Flexible Spending Account (FSA)		X		X	
Dependent Care Flexible Spending Account (FSA)		X		X	

Basic Life Insurance*		X		X	
Optional Life Insurance*		X		X	
MD State Retirement		X		X	
457B – Deferred Comp		X			X
AFLAC		X		X (If enroll outside of election period, contributions will be after tax)	
Christmas Club		X		September	

**Evidence of Insurability/medical underwriting is required for enrollment after new hire eligibility period.*

Human Resources conducts the Town's Open Enrollment process. If you would like assistance with making your elections, please contact HR at (410) 758-1180 ext.15 or by email at kebaugh@townofcentreville.org. Town of Centreville partners with Benecon to administer our health benefits and is working to streamline future Open Enrollment processes.

Enrollment Reminders

- **If you are adding a spouse and/or children onto your health insurance, you must submit dependent documentation to Human Resources. A marriage certificate is required for a spouse and a birth certificate for each child being enrolled along with Social Security cards. A copy of the Social Security card will be required for any new dependent.**

Making Changes to Your Benefits

The choices you make when you are first eligible are in effect for the remainder of the plan year that ends on June 30. Once you enroll, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualifying event as defined by the IRS.

The following are examples of a qualifying life event:

- Marriage, divorce, legal separation, annulment or death of a spouse
- Birth, adoption or placement for adoption
- Loss of health coverage
- Change in your dependent's eligibility status because of age or any similar circumstance

Life event changes must be made within 30 days of the qualifying event.

Lifestyle Change/Event	Documentation Required
Marriage	Marriage Certificate & Social Security Cards
Divorce	Divorce Decree
Legal Separation	Separation Agreement where the terms of the agreement permit a change in coverage
Birth or Adoption	Birth Certificate or Adoption papers & Social Security Cards
Change in employment status from part-time to full-time or vice versa	No documentation required – Human Resources will confirm
Your child loses eligibility for dependent coverage	No documentation required
Your spouse gains or loses coverage under another plan	Letter from spouse's employer verifying the change
You go on or return from leave of absence	No documentation required – Human Resources will confirm

Your Cost for Health Coverage

Your **PER PAYCHECK** payroll deductions for medical, dental, vision and pharmacy coverages are shown in the tables below. Premiums are deducted pretax from 24 paychecks, July 2023 through June 2024. Actual payroll amounts below may vary depending on coverage(s) elected.

Medical, Dental, and Vision Premiums

Cigna Choice Fund Health Reimbursement Account (HRA) Open Access Plus In-Network (Cigna):

Silver Plan – 85/15

Coverage Level	Employee Pays	Town Pays
Employee	$72.33	$409.87
Employee + Child	$133.80	$758.20
Employee + Spouse	$166.40	$942.92
Family	$202.56	$1,147.84
Deductible – Employee*	$0	$2,000
Deductible – Family*	$0	$4,000

Gold Plan – 85/15

Coverage Level	Employee Pays	Town Pays
Employee	$81.62	$462.51
Employee + Child	$150.98	$855.56
Employee + Spouse	$187.76	$1,063.96
Family	$228.57	$1,295.21
Deductible – Employee*	$0	$1,300
Deductible – Family*	$0	$2,600

***** *The Town established a health reimbursement account (HRA) and contributes up to 100% to pay for your eligible out-of-pocket expenses during the contract year.*

Metropolitan Life Insurance Company (MetLife):
Dental Plan – 85/15

Coverage Level	Employee Pays	Town Pays
Employee	$1.98	$11.24
Family	$6.26	$35.47

National Vision Administrators, LLC (NVA):
Vision Plan – 85/15

Coverage Level	Employee Pays	Town Pays
Employee	$0.35	$2.00
Family	$0.88	$4.99

Medical and Pharmacy Coverage

Main Features of Your Plan

Town of Centreville offers Cigna Open Access Plus In-Network with HRA which gives you access to a quality network of doctors, hospitals, facilities and labs that have contracted with your plan, and is located across the United States. Primary Care Provider (PCP) is optional but recommended to coordinate care. Cigna does not require a referral to see specialists. However, this plan covers you for in-network providers only. You will pay 100% of out-of-network care, except for emergencies. Both Cigna plans offered include medical, behavioral health, and Pharmacy coverage.

SILVER PLAN BENEFIT SUMMARY

BENEFIT SUMMARY
Cigna Health and Life Insurance Co. **For - Local Government Insurance Trust** **Choice Fund Open Access Plus IN HRA Plan** **Centreville HRA OAPIN Silver** **Effective - 07/01/2021**
Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.
Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the Contract Year.	
Employer Contribution	Employee - $2,000 Family - $4,000

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a contract year basis unless otherwise stated
Plan Coinsurance	Plan pays 90%
Maximum Reimbursable Charge	Not Applicable
Plan Deductible	Individual: $2,000 Family: $4,000

- Benefit copays always apply before plan deductible and coinsurance.
- All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Prescription medications used to prevent any of the following medical conditions are not subject to the individual and/or family plan deductible: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.

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

Plan Highlights	In-Network
Plan Out-of-Pocket Maximum	Individual: $6,000 Individual – In a Family: $6,850 Family: $12,000

- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	Plan pays 90% ^
Specialty Care Physician Services/Office Visit	Plan pays 90% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).	
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit
Cigna Telehealth Connection Services (Virtual Care)	Plan pays 90% ^

- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies
- Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).

Preventive Care	
Preventive Care	Plan pays 100%

- Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.
- Annual Limit: Unlimited

Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%

- Coverage includes the associated Preventive Outpatient Professional Services.
- Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.

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- All benefit copays contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- 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.
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- Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 90% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 90% ^
Inpatient Professional Services	Plan pays 90% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 90% ^
Outpatient Professional Services	Plan pays 90% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 90% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 90% ^
Ambulance	Plan pays 90% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 90% ^
Laboratory Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 90% ^
Outpatient Facility	Plan pays 90% ^
Radiology Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 90% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 90% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Outpatient Therapy Services	
Outpatient Therapy and Chiropractic Services	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 90 days • 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 therapy services maximum.	
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 90 days	
Hospice	
Inpatient Facilities	Plan pays 90% ^
Outpatient Services	Plan pays 90% ^
Note: Includes Bereavement counseling provided as part of a hospice program.	
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit
Medical Specialty Drugs	
Outpatient Facility	Plan pays 90% ^
Physician's Office	Plan pays 90% ^
Home	Plan pays 90% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 90% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Elective and non-elective procedures	
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.	
Other Health Care Facilities/Services	
Home Health Care	Plan pays 90% ^
• Annual Limit: Unlimited	
Note: Includes outpatient private duty nursing when approved as medically necessary	
Organ Transplants	
Inpatient Hospital Facility Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 90% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 90% ^
Routine Foot Care	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	
Hearing Aids • Annual Limit: Unlimited • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 18	Plan pays 90% ^

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Mental Health and Substance Use Disorder	
Inpatient mental health	Plan pays 90% ^
Outpatient mental health – Physician's Office	Plan pays 90% ^
Outpatient mental health – all other services	Plan pays 90% ^
Inpatient substance use disorder	Plan pays 90% ^
Outpatient substance use disorder – Physician's Office	Plan pays 90% ^
Outpatient substance use disorder – all other services	Plan pays 90% ^
Annual Limits: • Unlimited maximum Notes: • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc. • Services are paid at 100% after you reach your out-of-pocket maximum.	
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 Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $40 Non-Preferred Brand: You pay $75 **Retail (per 90-day supply):** Generic: You pay $25 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $188 **Home Delivery (per 90-day supply):** Generic: You pay $25 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $188
• Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan. • This plan will not cover out-of-network pharmacy benefits. • 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 brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW). • Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met. • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	
Preventive Drugs: Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network preventive drugs and products will not be subject to deductible. This applies to drugs for: • Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency	

Additional 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:

- Coverage includes Self Administered injectables and optional injectable drugs – includes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.

Pharmacy Program Information

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

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

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

Additional Information

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

Additional Information

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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; or (ii) 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
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 - Preferred Care Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician

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

Additional Information

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.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

Exclusions

- 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 deny 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 a 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.
- 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" sections 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" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- 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; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-

Exclusions

reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- 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.
- 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, pre-recorded 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.
- 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.

Exclusions

- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

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.

GOLD PLAN BENEFIT SUMMARY

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Local Government Insurance Trust
Choice Fund Open Access Plus IN HRA Plan
Centreville HRA OAPIN Gold
Effective - 07/01/2021

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

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

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the Contract Year.	
Employer Contribution	Employee - $1,300 Family - $2,600

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a contract year basis unless otherwise stated
Plan Coinsurance	Plan pays 100%
Maximum Reimbursable Charge	Not Applicable
Plan Deductible	Individual: $1,300 Family: $2,600

- Benefit copays always apply before plan deductible and coinsurance.
- All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Prescription medications used to prevent any of the following medical conditions are not subject to the individual and/or family plan deductible: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.

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

Plan Highlights	In-Network
Plan Out-of-Pocket Maximum	Individual: $2,600 Family: $5,200

- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^
Specialty Care Physician Services/Office Visit	Plan pays 100% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).	
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit
Cigna Telehealth Connection Services (Virtual Care)	Plan pays 100% ^
• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies • Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).	
Preventive Care	
Preventive Care	Plan pays 100%
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited	
Immunizations	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 100% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^
Inpatient Professional Services	Plan pays 100% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 100% ^
Outpatient Professional Services	Plan pays 100% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 100% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 100% ^
Ambulance	Plan pays 100% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 100% ^
Laboratory Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100% ^
Outpatient Facility	Plan pays 100% ^
Radiology Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 100% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Outpatient Therapy Services	
Outpatient Therapy and Chiropractic Services	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Chiropractic Care, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 90 days • 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 therapy services maximum.	
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 90 days	
Hospice	
Inpatient Facilities	Plan pays 100% ^
Outpatient Services	Plan pays 100% ^
Note: Includes Bereavement counseling provided as part of a hospice program.	
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit
Medical Specialty Drugs	
Outpatient Facility	Plan pays 100% ^
Physician's Office	Plan pays 100% ^
Home	Plan pays 100% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Elective and non-elective procedures	
Family Planning	
Women's Services	Plan pays 100%
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.	
Other Health Care Facilities/Services	
Home Health Care	Plan pays 100% ^
• Annual Limit: Unlimited	
Note: Includes outpatient private duty nursing when approved as medically necessary	
Organ Transplants	
Inpatient Hospital Facility Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services	
LifeSOURCE Facility	Plan pays 100%
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant	
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100% ^

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100% ^
Routine Foot Care	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	
Hearing Aids	Plan pays 100% ^
• Annual Limit: Unlimited • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 18	

Benefit	In-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays always apply before plan deductible.	
Mental Health and Substance Use Disorder	
Inpatient mental health	Plan pays 100% ^
Outpatient mental health – Physician's Office	Plan pays 100% ^
Outpatient mental health – all other services	Plan pays 100% ^
Inpatient substance use disorder	Plan pays 100% ^
Outpatient substance use disorder – Physician's Office	Plan pays 100% ^
Outpatient substance use disorder – all other services	Plan pays 100% ^
Annual Limits: • Unlimited maximum Notes: • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc. • Services are paid at 100% after you reach your out-of-pocket maximum.	
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 Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $40 Non-Preferred Brand: You pay $75 **Retail (per 90-day supply):** Generic: You pay $25 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $188 **Home Delivery (per 90-day supply):** Generic: You pay $25 Preferred Brand: You pay $100 Non-Preferred Brand: You pay $188
• Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies. • Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan. • This plan will not cover out-of-network pharmacy benefits. • 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 brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW). • Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met. • If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.	
Preventive Drugs: Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network preventive drugs and products will not be subject to deductible. This applies to drugs for: • Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency	

Additional 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:

- Coverage includes Self Administered injectables and optional injectable drugs – includes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.

Pharmacy Program Information

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

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

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

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

Additional Information

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

Additional Information

Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

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; or (ii) 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
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 - Preferred Care Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician

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

Additional Information

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.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

Exclusions

- 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 deny 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 a 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.
- 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" sections 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" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- 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; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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.
- For medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-

Exclusions

reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- 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.
- 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, pre-recorded 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.
- 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.

Exclusions

- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

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.

Connect Care 3

Empowering a healthier workforce

What is ConnectCare3?

ConnectCare3 is a confidential benefit provided to employees and their dependents covered under the health plan at no additional cost. ConnectCare3 has no affiliation with any insurance carrier or hospital system. We aim to provide callers with positive health outcomes on their health and wellness journey.

Available Services

Patient Advocacy

The patient advocates are the first line of contact when reaching out to ConnectCare3. They also assist our clinical team with conducting research.

Nurse Navigation

The nurse navigators are available to work with patients who have received a medical diagnosis that requires a specialist. Our nurses can provide education on a diagnosis and treatments, physician options, and can help patients prepare for physician appointments.

Chronic Disease Management & Prevention

The Chronic Disease Management & Prevention team consists of registered nurses, certified health coaches, and registered dietitians. Our team approach to preventing and managing chronic conditions provides you with access to resources and expertise all in one place.

Nutrition Education

Our registered dietitians will help patients to understand the connection between diet and health by completing a thorough nutritional assessment and providing healthy meal plans and alternatives.

Tobacco Cessation

Work one-on-one with our Tobacco Cessation coaches to achieve and maintain a tobacco-free life.

How to Enroll

Contact us at 877-223-2350 or info@connectcare3.com to enroll in our services today.

Sign Up to Receive Health & Wellness Updates

Scan the QR code to sign up to receive our health and wellness resources!

ConnectCare3®

For more information, visit connectcare3.com

Pharmacy Coverage

Some prescription drugs require prior authorization. This ensures you achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call to begin the prior authorization process. For the most up-to-date prior authorization list, visit

Prescription Drug Copay: Brand Name vs. Generic Equivalent

The copay is the dollar amount the pharmacy will collect for your prescriptions. If you choose a brand name prescription drug when a generic prescription drug is available, you will pay the appropriate copay plus the difference in cost between the brand name and the generic drug. Copays are determined by the type of prescription drug purchased.

Home Delivery Pharmacy Helps Save You Money

Home Delivery Pharmacy service offers a convenient and cost-effective way to fill prescriptions with fast, accurate home delivery. Plus, it is an easy way to save money on your maintenance medications. Once enrolled, you may take advantage of online self-service capabilities. Register at www.mycigna.com and have access to:

- Convenient switch to home delivery service
- Set-up automatic refills using Express Scripts Pharmacy from Cigna Healthcare
- View claims, balances and prescriptions history
- Manage account settings and payment methods

Dental Coverage

MetLife

Network: PDP Plus

DENTAL PLAN SUMMARY

Coverage Type:	**In-Network**[1] % of Negotiated Fee[2]	**Out-of-Network**[1] % of Negotiated Fee[2]
Type A - Preventive	100%	100%
Type B - Basic Restorative	100%	100%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible[3]		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit:		
Per Individual	$1500	$1500
Orthodontia Lifetime Maximum - Ortho applies to Child Only	Child to age 19	
	$1000 per Person	$1000 per Person
Dependent Age:	Eligible for benefits until the day that he or she turns 26.	

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.

Understanding Your Dental Benefits Plan

Good dental hygiene is important for your overall health. The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services – both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you. Once enrolled, you may take advantage of online self-service capabilities. Register at www.metlife.com/mybenefits and have access to:

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

Vision Coverage

National Vision Administrators, L.L.C.

VISION PLAN BENEFIT SUMMARY (Group Number #51381)

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every 12 Months	▪ Covered 100%	Reimbursed Amount ▪ Up to $32
Lenses Once Every 12 Months	Standard Glass or Plastic	
▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	▪ Covered 100%	▪ Up to $26 ▪ Up to $36 ▪ Up to $46 ▪ Up to $72
Frame Once Every 24 Months	Retail Allowance ▪ Up to $60 (20% discount off balance)*	▪ Up to $30
Contact Lenses Once Every 12 Months	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	▪ Up to $85 Retail⊕ (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $85
Medically Necessary***	▪ Covered 100%	▪ Up to $225

*Does not apply to Wal-Mart/Sam's Club or Lenscrafters locations or for certain proprietary brands.

**Does not apply to Wal-Mart/Sam's Club, Lenscradters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers.

***Pre-approval from NVA required.

To verify your benefit eligibility, visit www.e-nva.com or download their mobile app. You may also contact Customer Service at 1-800-672-7723 (TDD line 1-888-820-2990) or the Interactive Voice Response (IVR). Customer Service is available 24/7 and 365 days a year.

ΦAdditional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $12 Ultraviolet Coating
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $10 Scratch-Resistant Coating (Standard
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $10 Solid Tint
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- $80 AR Coating – Tier 4
- 20% discount AR Coating – Tier 5
- $50 Progressive Tier -1
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8
- $39 Retinal Screening

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U &C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

In MD, members may be required to pay the full retail amount and not the negotiated discount amount at participating providers.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	**Participating Provider**	**Lens Options**
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.
Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.
Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.
Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

Note: This vision benefit summary is intended as a program overview only and is not a certified document of the individual plan parameters. Please contact Human Resources, for details.

On Your Way to Wellness

The Human Resources Department is seeking volunteers to join our Wellness Committee. The purpose of this committee is to support all our efforts to enhance wellness throughout the Town:

- Improve an maintain your health, which is essential to enjoying a long life
- Reduce healthcare costs so that these dollars can be used for other purposes such as salaries, benefits and Town services
- Increase the use of your preventive services; if you can identify an issue early on, it is much easier to correct with a higher success rate (remember there are no copays!)
- Have fun with your co-workers competing in events and you can earn $$$!

Please contact Human Resources at kebaugh@townofcentreville.org, if interested.

Cigna Healthcare offers a variety of Wellness Programs; listed below are a few which may interest you and your family. These programs are free to you and any dependent enrolled in the health plan.

One-on-One Coaching

As part of your health coverage, you have access to personal health coaching. To learn more about the coaching program, or to join, call 1-800-244-6224. You may receive a call inviting you to participate. We encourage you to take advantage of this voluntary and confidential phone-based program that can help you achieve your best possible health. Not only can you decide how involved you want to be, you also have the ability to leave the program at any time.

Prepare for the Unthinkable

Group Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Town of Centreville provides Lincoln Term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance to all full-time eligible employees. The coverage is automatic and the premiums are 100% employer paid.

Lincoln Financial Group®
You're In Charge®

GROUP TERM LIFE AND AD&D BENEFIT SUMMARY

Coverage	**Benefit Amount Employee**
Life	$50,000
Guarantee Issue	$50,000
AD&D	Will Equal the Life Benefit
Benefit Reduction	**Employee**
Benefits will reduce:	35% at age 65; An additional 25% of original amount at age 70; An additional 15% of original amount at age 75; Benefits terminate at retirement
Additional Benefits	
See Understanding Your Benefits Page:	Accelerated Death Benefit Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Conversion Accident Plus
Enrolling for Coverage	**Employee**
Eligibility:	All employees in an eligible class.

Understanding Your Benefits	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Accident Plus	If loss occurs due to an accident, you may also receive the following Accident Plus benefits: Coma, Plegia, Repatriation, Education, Spouse Training, & Child Care. Refer to your certificate for more details.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Additional Benefits	
***LifeKeys*℠**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*℠**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **TOOFCEN2**	**www**.LincolnFinancial.com
If there is any discrepancy between this benefit summary and the policy, the policy shall control. This summary is not intended to contain a complete description of the coverage offered. This summary does not modify the policy. This is not a binding contract	

Protect Your Income!

Voluntary Life Insurance with Accidental Death and Dismemberment (AD&D)

Lincoln Financial Group®
You're In Charge®

SUMMARY

Life Benefit	Employee	Spouse	Dependent
	Employee must elect coverage for Spouse or dependents to be eligible.		
Amount	Choice of $10,000 increments	Choice of $5,000 increments	Day 1 to 6 months: $1,000 6 months to age 19 (to age 25 if full-time student): $10,000
Minimum Amount	$10,000	$5,000	$10,000
Maximum Amount	$300,000, limited to 5 times your annual salary Employees age 70 and older, maximum benefit is $50,000	$150,000, limited to 50% of employee amount	$10,000
Guarantee Issue for Newly Eligible Employee	$50,000	$10,000	
Current Eligible Employees	You or your Spouse may elect or increase insurance coverage equal to 2 benefit levels on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your Spouse have not been previously declined, withdrawn, or pending for coverage.		

AD&D Benefit	Employee	Spouse
Amount	Benefit amount equal to the life amount elected by you. Cost included in the schedule.	Same as employee

Benefit Reduction	Employee	Spouse
Benefits will reduce:	35% at age 65; Additional 25% of original amount at age 70; Additional 15% of original amount at age 75; Additional 15% of original amount at age 80; Benefits terminate at retirement	35% at Employee Age 65 Benefits terminate at Employee Age 70 or Retirement, whichever occurs first

Eligibility	Employee	Spouse and Dependents
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Additional Benefits	
See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion
See Definition:	Seat Belt, Airbag, and Common Carrier

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Seat Belt, Airbag, and Common Carrier	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Term Life	Benefit provided to the designated beneficiary upon the death of the insured. The benefit is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 1 year after coverage is effective. May apply if employee contributes toward the premium.
Additional Benefits	
***LifeKeys*℠**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*℠**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **TOOFCEN2**	www.LincolnFinancial.com

Additional Benefits

AFLAC Benefits

Employees may participate in an array of voluntary benefits including Accident, Cancer, Critical Care and Short-term Disability insurance. For more information, contact Matt Pastva, AFLAC Account Manager at 410-463-4162.

Worker's Compensation

All employees are covered by Worker's Compensation for injuries or illnesses occurring while performing normal work duties. For more information, refer to the Job-Injury Leave and Worker's Compensation Reporting Process Policy in the Personnel Manual.

Vacation Leave

Full-time employees earn vacation time based on years of service as outlined below.

- Zero through the end of 4 years of service: 4 hours per pay (Month = 8.67 hrs; Year = 104 hrs)
- Beginning the 5th year through 9 years of service: 6 hours per pay (Month = 13 hrs; Year = 156 hrs)
- Beginning the 10th year through duration of service: 8 hours per pay (Month = 17.33 hrs; Year = 208 hrs)

Employees accrue vacation time in accordance with this schedule from date of hire and may begin using this time following six months of employment.

Sick Leave

Full-time employees earn 4 hours of sick leave every pay period worked. Sick leave is prorated for part-time employees. Sick leave can be accumulated toward employee's state retirement in that every 22 days of sick leave is counted as one month of service toward retirement.

Personal Leave

Annually in January, full-time employees receive 24 hours of personal leave to use during the calendar year. For employees hired after January, the personal hours are prorated.

Holidays

Full-time employees receive 13 paid holidays annually. The recognized holidays are:

New Year's Day
Dr. Martin Luther King, Jr. Day
President's Day
Good Friday
Memorial Day
Juneteenth
Independence Day
Labor Day
Columbus Day
Veteran's Day
Thanksgiving Day
Day After Thanksgiving
Christmas Day

Employee Assistance Program (EAP)

Real support for real life. Confidential and no cost to you.

We recognize you may experience issues that affect your quality of life at home and at work, which has a great impact on your health. Cigna EAP provides access to work/life resources, and licenses clinicians to help you cope with a wide variety of concerns. Coverage is active for anyone who lives with the plan subscriber, including a nanny, parent, or in-law. Find out more by calling 1-800-244-6224, 24/7 or going online at www.mycigna.com.

The EAP Can Help with Many Issues Including:

- Workplace Stress
- Depression, stress, or anxiety
- Coping with illness
- Adjusting to life challenges
- Marriage and Relationship concerns
- Drug and Alcohol dependency
- And more!

Program Benefits Include:

- Up to 6 FREE counseling sessions with an EAP professional for you and your household members
- FREE financial consultation & referrals
- FREE legal consultation & referrals
- FREE childcare resources & referrals
- FREE eldercare resources & referrals
- FREE online Resource Library, with thousands of resources tailored to your specific life needs

Benefits are free, voluntary and confidential. For more information about the EAP services through Cigna, contact Cigna Healthcare at 1-800-244-6224 or see your Human Resources Representative.

Retirement Plans – Planning Your Future

Pension Plan

Town of Centreville is a proud member of the Maryland State Retirement and Pension System. Full-time and permanent part-time employees are enrolled in the plan and contribute 7% of base annual salary on a pretax basis. Likewise, the Town makes a mandatory contribution. Employees are vested after 10 years with full retirement and benefits paid after the employee has a combination of years of service and age totaling 90. The Law Enforcement Officers Pension System (LEOPS) is offered to sworn personnel working for the Centreville Police Department.

Deferred Compensation Plans

To enhance retirement savings, employees have the option of participating in a deferred compensation program, also called a 457(b) plan. A 457(b) plan allows employees to set aside funds on a pretax basis for retirement. The Town is happy to offer Mission Square and Corebridge Financial from which employees can select to invest.

Retiree Health Reimbursement Account (HRA) Stipend

The Town offers eligible retirees to join the HRA if 10 years of service has been vested with the Town prior to their effective retirement date. Please review the Summary Plan Description (SPD) or contact Human Resources for more details.

Questions?

Your Benefits Contacts

Benefit	Contact	Phone	Website or Email
General Benefit Questions	Human Resources	410-758-1180	kebaugh@townofcentreville.org
Medical and Pharmacy	Cigna Healthcare	1-800-244-6224	www.mycigna.com
Dental	MetLife Customer Support	1-866-832-5756	www.metlife.com/mybenefits
Vision	NVA Customer Support	1-800-672-7723	www.e-nva.com
Life Insurance	Lincoln Financial	1-800-423-2765; reference ID: TOOFCEN2	www.LincolnFinancial.com
Disability Insurance	Lincoln Financial	1-800-423-2765; reference ID: TOOFCEN2	www.LincolnFinancial.com
Flexible Spending Account	CareFlex	410-763-8787	www.careflex.com
AFLAC	Matt Pastva, Account Manager	410-463-4162	Matthew_pastva@us.aflac.com
457(b) – Def. Comp.	Corebridge Financial Mission Square Retirement	410-859-2164 800-669-7400	Susan.gallant@corebridgefinancial.com CSorokos@missionsq.org
Pension Plan	Maryland State Retirement and Pension System	410-625-5555	www.sra.maryland.gov
Retiree HRA Stipend	Human Resources	410-758-1180	kebaugh@townofcentreville.org

Annual Notices

Inside this issue:

BENECON

Introduction

This brochure includes the annual notices that should be distributed to all covered employees and dependents. This newsletter contains important information so we encourage you to read all sections.

If you have questions regarding any items contained in this newsletter, please contact your Human Resources office or plan administrator for more information.

We hope you find this information helpful and informative.

Summary of Benefits and Coverage

The Health Care Reform law states that all groups must implement the requirement that health plans and health insurers provide consumers with a Summary of Benefits and Coverage (SBC). The stated purpose of the SBC is to "accurately describe the benefits and coverage under the applicable plan or coverage," which will allow participants to better compare plan terms and benefits.

In addition, all group health plans will have to distribute a brief standard summary of benefits and must use and distribute a uniform glossary containing definitions for common terms (e.g. "copay", "deductible", etc.).

This should be distributed annually, no later than June 1st andwithin seven days per any employee request. The medical SBC will be created by the insurance carrier and provided to each group for distribution.

In addition, if your group has a stand-alone HRA or FSA that covers expenses beyond excepted benefits, then the plan sponsor, not the insurance carrier, will create and distribute that SBC.

Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

WHCRA Enrollment Notice

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator at the phone number on the back of your carrier ID card.

Patient Protections Disclosure Notice

You do not need prior authorization from the carrier 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 network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier by calling the number on the back of your ID card.

FOR GROUPS WITH HMO PLANS:
The employer's group health plan generally requires or allows 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. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier by calling the number on the back of your ID card.

Notice of Availability of Notice of Privacy Practices

Your group health plan (the Plan) is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations to maintain the privacy of your protected health information (PHI) and to provide plan participants with notice of its legal duties and privacy practices with respect to PHI. PHI is any individually identifiable information that is received or maintained by the Plan in electronic, written, or oral form that pertains to your past, present or future mental or physical condition, the provision of health care services for that condition, and the payment for those services.

The Plan is required by law to tell you:
The Plan's uses and disclosures of your PHI;
The Plan's duties with respect to your PHI;
Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and
The person to contact for further information about the Plan's privacy practices.

A copy of the Notice of Privacy Practices is available to all individuals whose PHI will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your Human Resources office or plan administrator.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your state for more information on eligibility -

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Maryland - Medicaid and MCHP

Medicaid Website:

health.maryland.gov/mmcp/pages/home/aspx

Medicaid Phone: 855-642-8571

MCHP Website:

https://www.marylandhealthconnection.gov

CHIP Phone: 855-642-8572

Delaware – Medicaid and CHIP

Website:

https://medicaid.dhss.delaware.gov

Phone: 1-800-372-2022

PENNSYLVANIA – Medicaid

Website:

https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx

Phone: 1-800-692-7462

To see if any other states have added a premium assistance program since January 31, 2022 or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 01/31/2023)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. Contact the Maryland Insurance Administration Department at www.insurance.maryland.gov or by phone at 1-800-492-6116 if you have difficulty finding a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Maryland Insurance Administration at **www.insurance.maryland.gov** or by phone at **1-800-492-6116.**

Visit **www.insurance.maryland.gov** for more information about your rights under federaland state law. You may also visit https://www.cms.gov/nosurprises for information from the federal government.

Notice of Dependent Enrollment Limitations

Newborns: Must be enrolled within **30 days** of birth. If they are not enrolled within this time frame, they are not eligible until the next open enrollment period. If no open enrollment period exists, they are not eligible until a Life Status Event occurs (which may not occur in many instances).

Adoption/Judgments/Decrees/Etc.: Must be enrolled as of effective date listed on legal documentation. Refer to Plan Document on day limitation (i.e.

Newborns' Act Disclosure

Group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

BENECON

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your human resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Helpful Contacts

AFLAC:

Matt Pastva, Account Manager	
Direct Line	410-463-4162
Email	matthew_pastva@us.aflac.com

Cigna Healthcare:

Accredo	1-877-826-7657
Benefits & Coverage	1-800-244-6224
Employee Assistance Program 24/7	1-800-244-6224
Health Information Line	1-855-673-3063
Health Reimbursement Account (HRA) 24/7	1-800-244-6224
Home Delivery Pharmacy	1-800-835-3784
Mental Health/Substance Use Coverage	1-800-433-5768
Medical Coverage	1-800-244-6224
MyCigna Website Help	1-800-853-2713
Traveling Abroad Coverage	1-866-763-8442

Cigna by Mail:

Medical Claims:
Cigna HealthCare, PO Box 182223, Chattanooga, TN 37422-7223

Pharmacy Claims:
Express Scripts, ATTN: Commercial Claims, PO Box 14711, Lexington, KY 40512

Home Delivery Pharmacy:
Mail your order form to: Express Scripts Pharmacy, PO BOX 66301, Saint Louis, MO 63166-6301

Health Reimbursement Account:
Cigna Choice Fund, PO Box 182223, Chattanooga, TN 37422-7223

TTY/TDD Service: For hard of hearing and deaf callers, call 711. Once connected, enter the toll-free number you are calling.

General Glossary of Terms

AD&D	Accidental Death & Dismemberment (AD&D) Insurance pays a benefit if you suffer certain types of injuries, such as the loss of a hand, foot, or eye as a result of an accident, or if you die as a result of an accident. AD&D coverage is automatically provided as part of your Basic Life Insurance.
Allowed Benefit	The fee an insurance company has negotiated with a provider to charge for covered services. Payment for covered services is based on this negotiated amount.
Annual Benefits Election Period	A designated timeframe for eligible employees to elect coverage who did not enroll during their initial eligibility period or for employees to make changes to their current benefits. Also referred to as Open Enrollment.
Basic Life Insurance	The group term life insurance provided at no cost to eligible employees.
Beneficiary	A person(s) or an entity (such as an association or organization) that you name to receive your life and AD&D insurance benefits if you die while covered; or to receive your vested account balances in your Retirement and Savings Program if you should die.
Brand Name Drug	A drug sold under a patented name by one company. Not all products identified as a “brand name” by the manufacturer, Pharmacy or your Physician may be classified as a Brand Drug under the plan.
Calendar Year	The period spanning from January 1 to December 31 of each year.
Coordination of Benefits (COB)	A provision of the insurance industry which limits benefits if you are covered under multiple insurance plans. Benefits are limited to 100% of covered expenses. The order in which insurance companies are paid is also designated by this provision.
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. Coinsurance is not the same as, and does not include, copay.
Copayment (Copay)	A flat fee you pay for certain covered services such as doctor’s visits or prescriptions.
Covered Expenses	Charges that are paid in part, or in full, by the plan.
Deductible	A flat dollar amount you must pay out of your own pocket before

	your plan begins to pay for covered services.
Dependent	The definition of a "dependent" will vary according to each plan. Dependents under the medical, dental, vision, or health flexible spending plan are: 1) an employee's law spouse; and 2) and employee's child who a) is less than 26 years old, b) 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Please contact Human Resources for details.
Dependent Care Expenses	Monthly expenses charged by a daycare provider (maximum of $5,000 per plan year) who is not your spouse, or someone claimed by you as a dependent.
Fiscal Year	A fiscal year is a 12-month accounting period that a business uses for financial and tax reporting purposes. A fiscal year is also known as a financial year. The Town recognizes their fiscal year beginning July 1 and ending June 30 of the following year. The benefit plan year follows the Town's fiscal year for budgeting purposes.
Flexible Spending Account (FSA)	Flexible Spending Account (FSA) allows you to set aside pre-tax dollars for unreimbursed medical, prescription, vision, and dental expenses, and dependent care costs.
Generic Drug	A drug that may be sold under more than one name, by more than one company. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan.
Guaranteed Issue	A provision that allows you to purchase insurance coverage regardless of the health of you and/or your spouse.
Health Reimbursement Account (HRA)	An employer-funded account that helps pay for qualified health care expenses.
In-Network Benefits	Benefits that are paid at a higher level when you use network participating providers.
Long-Term Disability (LTD)	This type of insurance provides a percentage of your income if you become totally disabled. It is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.
Medical Evidence of Insurability	If you do not purchase life insurance when it is first offered, or within 30 days of your date of eligibility, you must complete a health questionnaire in order to be approved for the plan, thus

	providing evidence that you are insurable. The insurance company will review your health information and determine whether or not they will provide coverage to you. The insurance company may take several months to determine whether or not they will provide you with coverage.
Non-Preferred Provider	A provider who does not have any agreement with your insurance plan to accept copays or reduced fees for services rendered.
Open Access Plus (OAP) Network	Is a group of doctors, hospitals, facilities and labs that have contracted with your plan, and is located across the United States.
Open Enrollment	See “Annual Benefits Election Period”.
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% of the “Maximum Reimbursable Charges” or negotiated fees for covered services.
Out-of-Network Benefits	Benefits that are paid at a lower level when you use out-of-network providers.
Participating Provider	A provider that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Chares for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.
Place of Service	Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Plan Year	The period spanning from the beginning of the benefit plan year to the end of the benefit plan year. Currently for Town of Centreville this is from July 1 to June 30 of the following year.
Plan Document	A comprehensive written instruction describing the operation and administration of an employer’s plan. The plan document is written in legalese and may be difficult for the average participant to read and understand. Section 402 of ERISA requires that benefit plans subject to the regulations must be established and maintained according to a written instrument. The plan document tells the plan participants about the benefits they are entitled to under the plan and provides guidelines to be used by the plan administrator in decision-making when it comes to plan operations. It is not required to be distributed to the participants unless requested.

Pre-Existing Condition	Any health condition for which the patient has already received medical advice or treatment prior to the effective date of a new insurance plan. Benefits for this condition may not be paid for the first 12 months of coverage. See specific plan details of the benefit plan for more information.
Premium Only Plan (POP)	Also referred to as "Section 125 Plan". According to Internal Revenue Code (IRC) Section 125 to allow eligible employees to elect to pay for their portion of insurance premiums on a pre-tax basis. This Plan is for the exclusive benefit of the Participants and the Participant's Beneficiaries. Refer to Plan Documents for participation eligibility requirements. Contact Human Resources for more details.
Prescription Drug List	The list of prescription brand and generic drugs covered by your pharmacy plan, or that by law must be dispensed with a prescription.
Qualifying Event	An occurrence that entitles a person to select or change benefits outside of the defined "Open Enrollment" period. Events could include but are not limited to termination of employment, death of a covered person, marriage, divorce, birth, adoption, Medicare eligibility, a dependent child's loss of dependent status, or commencement of or return from an unpaid leave of absence.
Short-Term Disability (STD)	This type of insurance provides a percentage of your income if you become temporarily disabled.
Summary Plan Description (SPD)	A summary of the plan document required to be written in such a way that the participants of the benefits plan can easily understand it. SPD is required to be distributed to plan participants.
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.