HEALTH COVERAGE WITH CONFIDENCE

Ultimate PPO

Straightforward coverage for the people who matter most.

A clear overview of in-network benefits, prescription coverage, monthly rates, and important plan details.

$0 DEDUCTIBLE

NO SPECIALIST REFERRAL

COVERAGE FOR INDIVIDUALS AND FAMILIES | PLAN TYPE: PPO

Your plan at a glance

Core benefits and monthly coverage rates

$0 / $0 IN-NETWORK

Individual / family deductible

$0 / $0 IN-NETWORK

Individual / family out-of-pocket max

MONTHLY COVERAGE RATES

Select the coverage tier that fits your household.

M	**Member only** MONTHLY	**$949.00**
S	**Member + spouse** MONTHLY	**$1,799.00**
C	**Member + children** MONTHLY	**$1,699.00**
F	**Family** MONTHLY	**$2,299.00**

WHAT TO KNOW

In-network deductible: $0 individual / $0 family. The individual and family limits are embedded.

PPO network flexibility. In-network medical services shown here are generally covered at no charge. Confirm provider participation at Cigna.com before receiving care.

In-network out-of-pocket maximum: $0 individual / $0 family. The individual and family limits are embedded.

Not counted toward the limit: premiums, balance-billing charges, pre-certification penalties, and noncovered care.

Benefits and limits accumulate on a calendar-year or plan-year basis.

Everyday care and prescriptions

Common in-network services and pharmacy benefits

EVERYDAY CARE

Visits, tests and urgent needs

SERVICE	IN-NETWORK	DETAILS
Primary care visit	**No charge**	Treatment for injury or illness
Specialist visit	**No charge**	No referral required
Preventive care	**No charge**	Screenings and immunizations
Diagnostic tests	**No charge**	X-rays and blood work
Advanced imaging	**No charge**	CT, PET scans and MRIs
Urgent care	**No charge**	Urgent medical attention

PRESCRIPTION COVERAGE

Four clear pharmacy tiers

DRUG TIER	IN-NETWORK	DETAILS
Generic	**$0 retail or mail order**	Retail and mail order
Preferred brand	**$35 retail / $105 mail order**	Prior authorization may apply
Non-preferred brand	**$75 retail / $225 mail order**	Prior authorization may apply
Specialty	**$200 per prescription**	$2,500+ monthly: PBM advocacy

PLAN QUICK GUIDE

In-network: $0 deductible and $0 out-of-pocket maximum.

Specialists: No referral is required.

Prescriptions: Prior authorization may be required for certain drugs.

PHARMACY NOTES

- Prior authorization may be required for certain drugs.
- Benefits may vary for supplies longer than 30 days.
- Specialty drugs with a gross monthly cost of $2,500 are covered when coordinated with the PBM Patient Advocacy Program. The plan may permit at least one 30-day fill for each of these drugs during the year.
- More prescription information is available through VerusRx.

When care becomes more serious

Outpatient, emergency, hospital, behavioral health and maternity care

OUTPATIENT AND EMERGENCY

Care when and where you need it

SERVICE	IN-NETWORK	DETAILS
Outpatient facility	**No charge**	Pre-certification required
Outpatient physician / surgeon	**No charge**	Physician and surgeon fees
Emergency room	**No charge**	Emergency care
Emergency transportation	**No charge**	Emergency medical transport
Urgent care	**No charge**	Urgent medical attention

HOSPITAL AND FAMILY CARE

Inpatient, behavioral health and maternity

SERVICE	IN-NETWORK	DETAILS
Hospital facility	**No charge**	Pre-certification required
Hospital physician / surgeon	**No charge**	Physician and surgeon fees
Mental health - outpatient	**No charge**	Outpatient services
Mental health - inpatient	**No charge**	Pre-certification required
Maternity office visits	**No charge**	Office visits
Childbirth professional	**No charge**	Professional services
Childbirth facility	**No charge**	Post-certification may apply

PRE-CERTIFICATION MATTERS

A $500 penalty applies when required pre-certification is not obtained. Confirm requirements before outpatient surgery, hospital admission, residential treatment, skilled nursing care, or certain equipment services.

MATERNITY STAY NOTICE

Post-certification is required when a maternity stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. A $500 penalty applies if required certification is not obtained.

Recovery, family services and exclusions

Additional covered services, annual limits and services generally not covered

RECOVERY AND SPECIAL NEEDS

Support beyond the doctor's office

SERVICE	IN-NETWORK	DETAILS & LIMITS
Home health care	**No charge**	60 visits/year
Rehabilitation	**No charge**	35 visits/year combined with habilitation
Habilitation	**No charge**	35 visits/year combined with rehabilitation
Skilled nursing	**No charge**	25 days/year; pre-certification required
Durable medical equipment	**No charge**	Pre-certification required for DME, orthotics and prosthetics
Hospice	**No charge**	Physician renewal every 60 days

CHILDREN AND OTHER COVERED SERVICES

Children's eye exam: No charge; one exam per year.

Children's glasses: Not covered.

Children's dental check-up: Not covered.

Chiropractic care: Covered with a limit of 25 visits per year.

SERVICES THE PLAN GENERALLY DOES NOT COVER

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Adult dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care outside the U.S.
- Private duty nursing
- Adult routine eye care
- Routine foot care
- Weight loss programs

Coverage examples and important information

Sample situations from the plan's Summary of Benefits and Coverage

These examples are not cost estimators. Actual costs depend on the care received, provider prices and other factors.

Peg is having a baby

9 months of in-network prenatal care and hospital delivery

TOTAL EXAMPLE COST	**$12,700**
Deductible	$0
Copayments	$0
Coinsurance	$0
Limits / exclusions	$0
ESTIMATED MEMBER TOTAL	**$0**

Managing Joe's type 2 diabetes

A year of routine in-network care for a controlled condition

TOTAL EXAMPLE COST	**$5,600**
Deductible	$0
Copayments	$0
Coinsurance	$0
Limits / exclusions	$0
ESTIMATED MEMBER TOTAL	**$0**

Mia's simple fracture

In-network emergency room visit and follow-up care

TOTAL EXAMPLE COST	**$2,800**
Deductible	$0
Copayments	$0
Coinsurance	$0
Limits / exclusions	$0
ESTIMATED MEMBER TOTAL	**$0**

IMPORTANT INFORMATION

Your right to continue coverage. Assistance may be available if coverage ends. Contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or visit dol.gov/ebsa/healthreform. Other options may be available through HealthCare.gov or 1-800-318-2596.

Grievances and appeals. Review the explanation of benefits and plan documents for claim, appeal and grievance procedures. You may also contact the Department of Labor at the number above.

Minimum Essential Coverage: Yes. Minimum Value Standard: Yes.

Language access services:
Spanish: Para obtener asistencia en Espanol, llame al 1-855-699-5433.
Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-699-5433.
Chinese: For assistance in Chinese, call 1-855-699-5433.
Navajo: For assistance in Navajo, call 1-855-699-5433.

Summary notice. This brochure is a convenient overview, not the insurance contract. If this brochure differs from the official plan document, the plan document controls. For definitions of common coverage terms, visit healthcare.gov/sbc-glossary.