BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - Clayton Homes, Inc.
Open Access Plus Plan
Simple Plus Plan
Effective - 01/01/2027

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

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	110% (please reference page 9)
Plan Deductible	Individual: None Family: None	Individual: $3,000 Family: $6,000

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.
- Services where plan deductible applies are noted with a caret (^).

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Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $4,000 Family: $8,000	Individual: $8,000 Family: $16,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Out-of-Network Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit • PCP Includes: OB/GYNs, GYNs, Pediatricians, Family Practitioners, General Practitioners, Internal Medicine, Certified Nurse Midwife, Nurse Practitioner, Physician Assistants and MH/SUD Therapists • PCP benefit applies regardless of place of service • Convenience Clinic/Minute Clinic visits will be considered a PCP office visit	$30 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit • Any provider not defined as a PCP (by Clayton's definition) is considered a Specialist.	$70 copay, and plan pays 100%	Plan pays 60% ^
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum • Allergy serum dispensed by the physician in the office • Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	$0 copay, and plan pays 100%	Not Covered
MDLIVE Primary Care Services	$0 copay, and plan pays 100%	Not Covered
MDLIVE Specialty Care Services	$0 copay, and plan pays 100%	Not Covered
• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care. • For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs. • Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$70 copay, and plan pays 100%	Plan pays 60% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. • 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).		
Convenience Care Clinic		
Convenience Care Clinic	$30 copay, and plan pays 100%	Plan pays 60% ^
Preventive Care		
Preventive Care - All Ages	Plan pays 100%	PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
• 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.		
Immunizations (Includes Travel Immunizations In-network only) - All Ages	Plan pays 100%	PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.		
Colorectal Cancer Screening and Sigmoidoscopy	Plan pays 100%	Covered same as other x-ray and lab services, based on place of service
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Inpatient Hospital Facility Services	$750 per day copay, and plan pays 100%	Plan pays 60% ^
• Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 60% ^
Inpatient Professional Services	Plan pays 100%	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	$425 per facility visit copay, and plan pays 100%	Plan pays 60% ^
Outpatient Professional Services	Plan pays 100%	Plan pays 60% ^
• 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. • Per visit copay is waived if admitted.	$500 copay, and plan pays 100%	$500 copay, and 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.	$50 copay, and plan pays 100%	Plan pays 60% ^
Ambulance	$350 benefit deductible per day and Plan pays 100%	$350 benefit deductible per day and Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Ambulance - Mental Health and Substance Use Disorder	Plan pays 100%	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: Unlimited days	$750 copay per day and Plan pays 100%	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 60% ^
Independent Lab	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	Plan pays 100%	Plan pays 60% ^

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Radiology Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	$60 copay and plan pays 100%	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	$240 copay per type of scan per day, and plan pays 100%	Plan pays 60% ^
Physician's Services/Office Visit	$240 copay per type of scan per day, then covered same as Physician Services – Office Visit coinsurance	Plan pays 60% ^
Outpatient Therapy Services		
Outpatient Therapy and Chiropractic Services	$40 copay and Plan pays 100%	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Chiropractic Care, Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 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.		
Hospice		
Inpatient Facilities	Plan pays 100%	Plan pays 60% ^
Outpatient Services	Plan pays 100%	Plan pays 60% ^
• Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
• Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceutical Drugs		
Outpatient Facility	$150 copay and Plan pays 100%	Plan pays 60% ^
Physician's Office	$150 copay and Plan pays 100%	Plan pays 60% ^
Home	$150 copay and Plan pays 100%	Plan pays 60% ^
• 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.		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 60% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services • Elective and non-elective procedures	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Family Planning		
Women's Services • Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)	Plan pays 100%	Coverage varies based on Place of Service
Men's Services • Includes surgical sterilization services, such as vasectomy (excludes reversals) Vasectomy - Surgery covered at 100% - all other charges based on place of service	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility		
Infertility Treatment • Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.		
Outpatient Dialysis Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Not Covered
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit	Not Covered
Home Dialysis	Plan pays 100%	Not Covered
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit	Not Covered
Other Health Care Facilities/Services		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Home Health Care • Annual Limit: Unlimited • Per provider type/day copay (i.e. Nurse + Physical Therapist + Wound Care CNA = 3 copays) **Note:** Includes outpatient private duty nursing when approved as medically necessary	$25 copay per day and Plan pays 100%	Plan pays 60% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	$750 per day copay, and plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	$750 per day copay, and plan pays 100%	Plan pays 60% ^
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Plan pays 100%	Plan pays 60% ^
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant • Unlimited maximum per procedure		
Durable Medical Equipment • Annual Limit: Unlimited	$100 annual benefit deductible and plan Plan pays 100%	Plan pays 60% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 60% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	$100 annual benefit deductible and Plan pays 100%	Plan pays 60% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited lifetime maximum • Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Bariatric Surgery • Surgeon Charges Lifetime Maximum: $10,000	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision		
Routine Foot Care • Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Hearing Aids	$100 annual benefit deductible and Plan pays 100%	Plan pays 60% ^

- Annual Limit: Age 18 and Over: $3k maximum per device for 2 devices every 2 years
- Annual Limit: Age 17 and Under: 2 devices every 2 years
- Includes testing and fitting of hearing aid devices at Physician Office Visit cost share

Mental Health and Substance Use Disorder

Inpatient Mental Health	$750 per day copay, and plan pays 100%	Plan pays 60% ^
Outpatient Mental Health - Physician's Office	$30 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Mental Health - MDLIVE Behavioral Services	$0 copay, and plan pays 100%	Not Covered
Outpatient Mental Health - All Other Services	$30 copay, and plan pays 100%	Plan pays 60% ^
Inpatient Substance Use Disorder	$750 per day copay, and plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder - Physician's Office	$30 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	$0 copay, and plan pays 100%	Not Covered
Outpatient Substance Use Disorder - All Other Services	$30 copay, and plan pays 100%	Plan pays 60% ^

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All other services - may include partial hospitalization, intensive outpatient services, Applied Behavior Analysis (ABA therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Annual Limits:

- Unlimited maximum

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

Cigna Healthcare Enhanced Behavioral Health

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- In-the-moment consultation and scheduling
- 100% follow-up with a Care Navigator
- Digital portal for assessment and care recommendation
- Community support program to address social determinants of health factors.
- Digital tools for self-guided support for increased resiliency

Pharmacy

Benefits not provided by Cigna.

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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.

Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$250 (1st trimester) / $125 (2nd trimester) - Option 2

Maximum Reimbursable Charge
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the Maximum Reimbursable Charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and Maximum Reimbursable Charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the in-network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (out-of-network) provider.
2. The allowable amount used to determine the plan's benefit payment for covered Emergency Services rendered in an out-of-network hospital, or by an out-of-network provider in an in-network hospital, is the amount agreed to by the out-of-network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

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

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

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.

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Additional Information

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

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
  Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.

- Benefits are denied for any additional days not certified by Cigna Healthcare.

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

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
  Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

Well-Being Solution: Core

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections

Definitions

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

Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.

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Exclusions

- 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:) acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

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Exclusions

- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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 medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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.

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These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: TN

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Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare:

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

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

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Proficiency of Language Assistance Services

English – ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

Chinese – 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

Vietnamese – XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

Korean – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

Tagalog – PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

Russian – ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

Arabic - تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711 :TTY) 1-800-244-6224

French Creole – ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

French – ATTENTION : Si vows parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

Portuguese – ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

Polish – UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

Japanese – 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

Italian – ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

German – Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره1-800-244-6224.ارائه‌دهنده خود صحبت کنید