2026-2027 BENEFITS

Enrollment & Reference Guide

Town of Suffield CT

YOUR BENEFITS EFFECTIVE

JULY 1, 2026

WPCA Eligible Employees

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This enrollment and reference guide has been designed for all eligible WPCA employees of The Town of Suffield.

This guide contains brief descriptions of the options provided in each benefit category. These summaries are intended to help you choose among the available options under the benefits program. This guide does not take the place of the legal plan documents. If there is a conflict between this enrollment guide and the plan documents, the plan documents will govern. If you require more detailed information, contact the The Town of Suffield's Human Resources Department.

The Town of Suffield reserves the right to modify, amend, or terminate any or all of the provision of these plans at any time for any reason.

The Health Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to limitation or exclusion, a Covered Person still has the right and privilege to receive such medical services or supply at the Covered Person's own personal expense.

Each year, The Town of Suffield offers a benefits Open Enrollment period so that employees have an opportunity to re-evaluate and make changes to their enrollment in some benefit plans.

For the 2026-2027 Plan Year Open Enrollment applies to the following benefits plans:

Medical: Cigna - HSA6

Vision: Cigna

Dental: Cigna - DPPO4

Supplemental Plans: Accident, Hospital, Critical Illness

All changes made during Open Enrollment are effective July 1, 2026.

This Booklet and the accompanying materials will help you understand what plans are offered. Review it carefully and determine which plans you wish to participate in during the upcoming plan year.

ABOUT YOUR BENEFITS

It is important to ensure that you and your family have the coverage you need when you need it most. Because different people have different needs, The Town of Suffield offers you a choice of benefits. They help you obtain these benefits and covers a significant portion of their costs. You pay for the balance through payroll deductions.

CONTACT INFORMATION

Provider Name	Phone	Website	Group #
Cigna (medical, dental, vision)	800-244-6224	www.mycigna.com	3341783
Cigna (accident, hospital, illness)	800-754-3207	SuppHealthClaims.com	3341783
Reliance Standard (life and disability)	800-351-7500	Life Policy: GL167657	
		Short Term Disability: STD170543	
		Long Term Disability: LTD430636	

WHO IS ELIGIBLE?

All full-time regular employees regularly scheduled to work at least 20 hours per week, and eligible dependents, may participate in the The Town of Suffield medical, vision and dental coverage.

Your eligible dependents include:

Your spouse

Your children up until the end of the month in which they turn age 26 for medical and 27 for vision plans
Your children up until the end of the month in which they turn 23 in the dental plan

HOW YOUR BENEFITS WORK

The Town of Suffield benefits program offers you a selection of benefit plans that you can tailor to meet your needs.

You can elect only the benefits plans you and your family needs.

You can decline some coverage that you do not need.

You can evaluate your benefit coverage and change every year during the annual Open Enrollment period.

After Open Enrollment ends, due to plan rules and IRS regulations, you cannot change your elections unless you have a “Qualified Change of Status”.

A “Qualified Change of Status” is generally defined as:

Marriage or divorce

Birth, adoption, or placement for adoption

Death of dependent

Change in dependent’s employment status (new employment, change in hours or status which affect eligibility for coverage)

Termination of dependent’s employment and subsequent loss of coverage

Losing or gaining eligibility for Medicaid, Medicare, or Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP

Over-age child (A child can be covered until age 26 in the medical, age 27 for vision or until age 23 for dental.)

A Qualified Change in Status must be reported to HR within 30 days of the event.

WHEN COVERAGE BEGINS AND ENDS

Coverage as a new hire will begin the first day of the month following 30 days. Changes made during the annual Open Enrollment period for medical, dental and vision benefits are effective July 1st.

PAYING FOR YOUR BENEFITS

Benefits are an important part of you total compensation. The Town of Suffield provides coverage for some benefits at no cost to you as outlined below. Your contributions – the amount you pay for your benefits – are automatically deducted from your paycheck.

Pre-Tax Options

Your benefit contribution are deducted from your paycheck on a before-tax basis. (except domestic partner coverage)

- Medical coverage for you and your dependents
- Dental Coverage for you and your dependents
- Vision coverage for you and your dependents
- Supplemental Health Plans (critical illness, accident, and hospital)

PRE-TAX DEDUCTION AUTHORIZATION SALARY REDUCTION AGREEMENT

By enrolling in the medical, dental, vision, or supplemental coverage, you are authorizing The Town of Suffield to make a pre-tax deduction from your paycheck each pay period. It equals your share of the insurance premium.

The authorization revokes any previous salary reduction agreement you may have. The deduction authorization remains in effect for all future Plan Years unless revoked or modified.

MEDICAL PLAN HIGHLIGHTS

CIGNA HSA 6 - MEDICAL PLAN

Type of Care	In Network	Out of Network
Primary Care Doctor Visit	0% after deductible	20% after deductible
Specialist Doctor Visit	0% after deductible	20% after deductible
Preventive Visit	0% after deductible	20% after deductible
Pharmacy	$5/30/45 after deductible MO 1x/2x/2x	Not Covered
Emergency Room	0% after deductible	0% after deductible
Urgent Care	0% after deductible	20% after deductible
Hospital Stay	0% after deductible	20% after deductible
Basic Diagnostic (Lab)	0% after deductible	20% after deductible
Basic Diagnostic (X-Ray)	0% after deductible	20% after deductible
Advanced Diagnostic (MRI/CT Scan)	0% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible
Deductible (Individual/Family)	$2,000/$4,000	$2,000/$4,000
Deductible (Plan/Calendar Year)	Calendar Year	Calendar Year
Coinsurance	0%	20%
Out of Pocket Maximum (Individual/ Family)	$4,000/$8,000	$4,000/$8,000

Enrollment Tier	Monthly Cost to You
Employee Only	$236.82
Employee + One	$426.28
Employee + Family	$663.10

Refer to certificate of insurance for complete plan details.

HEALTH SAVINGS ACCOUNT (HSA)

HSAs are tax-advantaged savings accounts that are available to employees who are enrolled in a High Deductible Health Plan. The account is employee-owned, and money may be contributed by both the employer and employee to the account. Suffield will contribute 35% of the deductible into the HSA for enrollees. The employee owns the account and remains in control of the funds in the account. The account is portable, and you may continue to make deposits into the account as long as you are enrolled in a compli-ant HDHP.

The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds to pay for non-qualified expenses. Funds roll over year after year if you don't spend them, and can accumulate a signif-icant balance. There is a limit to how much money can be put into an HSA every year, but no limit on how much money can be in the account.

Why would I open an HSA?
You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses. In addition, because contributions are made on a pre-tax basis, you are lowering your taxable income. Lastly, any unused funds that you deposit into the HSA are available for you to use year after year, since the money rolls over and can continue to be utilized if you choose to leave Suffield.

Can I add my own pre-tax dollars to the HSA?
Yes, you can make contributions of up to $4,500 in Calendar Year 2027 if you have employee only coverage, or $9,000 for all other levels of coverage. If you are over age 55, you can contribute an additional $1,000 in 2027 as a "catch-up" contribution.

Does Suffield open an HSA for me?
When you enroll in a HIgh Deductible Health Plan, an HSA will be opened for you. You will receive a welcome kit and debit card in the mail. You must complete the enrollment process by providing confirmation of your identity. If you do not complete the enrolment process you cannot access the funds deposited. You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses.

What happens to any money I don't use in 2027?
Your HSA funds will roll over, year after year. They belong to you.

If I leave employment, what happens to my HSA?
Your HSA is portable, so if you leave employment for any reason, your HSA goes with you.

Can I withdraw money from a HSA for non-medical expenses?
Yes, but if you withdraw funds for non-medical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you don't have a penalty, but you must still pay ordinary income taxes on the money you withdraw for non-medical expenses.

Can I use the money in my HSA account to pay for my dependents' medical expenses?
You can use the money in the account to pay for the medical expenses of yourself, your spouse or your dependent children, whether they are covered by the plan or not. Please note that domestic partner expenses should not be paid using your HSA.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

VISION PLAN

CIGNA

The vision plan provides vision care through Cigna's network, which includes those in private practice as well as retail chains. When making an appointment with a network provider, please identify yourself as a participant in this vision plan. If purchased through the provider network, eye examinations and eyewear will result in less out of pocket cost to you and your enrolled dependents; however, the plan does provide out of network coverage as well. The high level benefits are as follows:

	In Network	Out of Network
VISION		
Exam	No cost	up to $75
LENSES		
Single	$20 copay	up to $40
Bifocal	$20 copay	up to $65
Trifocal	$20 copay	up to $75
Lenticular	$20 copay	up to $100
Progressive	$20 copay	up to $75
CONTACTS		
Elective	Amount over $130 (discounts apply)	Amount over $105
Medically Necessary	Covered in full	Amount over $210
FRAMES		
Benefit	80% amount over $130	up to $71

Enrollment Tier	Monthly Cost to You
Employee Only	$7.08
Employee + One	$12.38
Employee + Family	$19.81

See certificate of insurance for complete plan details

DENTAL PLAN

CIGNA - DPPO4

	IN NETWORK	OUT OF NETWORK
Annual Maximum	$1,000	$1,000
Orthodontia Maximum	$1,000	$1,000
Deductible • Individual • Family	 $50 $150	 $50 $150
Dedcutible (Plan/Calendar Year)	Calendar Year	Calendar Year
Preventive	100%	100%
General Anesthesia	Not Covered	Not Covered
Basic Services	80%	80%
Major Services	50%	50%
Orthodontia	50%	50%
Periodontal Surgery	50%	50%
Major and Minor Periodontoics	50%	50%

Enrollment Tier	Monthly Cost to You
Employee Only	$7.80
Employee + One	$15.44
Employee + Family	$32.88

See certificate of insurance for complete plan details

CIGNA SUPPLEMENTAL HEALTH PLANS

All eligible employees will have the opportunity to enroll in Cigna's Supplemental Health plans. An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional and financial well-being. Regular expenses, big and small, can add up. These voluntary benefits are designed to help strengthen your overall benefits package and provide additional protection for you and your family through fixed benefits paid directly to YOU.

Key Features to Consider:
› Flexible. Use the money however you want. Pay for anything you need – medical deductibles, child care, groceries, etc.
› Supplement your medical plan. Benefits are paid in addition to other coverage you may have.
› Cost effective. Your premium is conveniently deducted from your paycheck at a low group rate.

ACCIDENTAL INJURY INSURANCE

Pays a fixed cash benefit directly to you when you have a covered accident- related injury, like an ankle sprain or arm fracture.

Accidental Injury Benefit Example Situation: Chloe broke her leg playing soccer.
Chloe's covered benefits:
› Doctor's officevisit › Broken leg
› Diagnostic exam (X-ray) › Physical therapy sessions
Accidental Injury benefit paid directly to Chloe: $1,200

CRITICAL ILLNESS INSURANCE

Pays a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition, such as a heart attack or stroke.

Critical Illness Benefit Example Situation: Marco had a heart attack while raking leaves.
Marco's covered benefits:
› Heart attack diagnosis
Critical Illness benefit paid directly to Marco: $10,000

HOSPITAL CARE INSURANCE

Pays a fixed cash benefit directly to you[1] when you experience a covered hospital[3] stay, for events like an in-patient procedure or childbirth.

Hospital Care Benefit Example Situation: Susan was hospitalized2 following a car accident.
Susan's covered benefits:
› Hospital admission › Hospital ICU stay
› Hospital stay
Hospital Care benefit paid directly to Susan: $1,400

WELLNESS INCENTIVE BENEFITS

Your Cigna Supplemental Health plan(s) comes with a Wellness Incentive benefit. This benefit is paid to each covered person who completes at least one wellness treatment, health screening test or preventive care service.

If you are interested in enrolling, please indicate your elections during Open Enrollment.

Please note the above descriptions are only a brief summary and examples are provided for illustrative purposes only. Refer to the Benefit Summaries for more details on your coverage, election options, and rates.

TotalCare EAP
A division of ESI

Your EAP Benefit Summary



Each of us encounters personal problems from time to time. We partner with ESI EAP to provide you with the best possible solutions for issues you or your family may face. **Your EAP is here to help.**

The following free benefits are available for Employees and Family Members.

Counseling Benefits

Help from experienced Masters or Ph.D. level counselors for personal issues such as: relationships/ family, depression/anxiety, grief and more. Multiple counseling options include in-the-moment telephonic, live therapy through text messaging, chat, audio, and video, and in-person therapy.

Peak Performance Coaching

Personal and professional coaching is available from senior-level ESI coaches. Get one-to-one telephonic coaching and support, as well as online self-help resources and trainings.

Training And Personal Development Benefits

Access to our extensive library of online personal and professional development trainings in a variety of easy-to-use formats. Some training topics include: debt, budgeting, communication, business skills, working remotely, stress management, and emotional intelligence.

Talkspace Go App

A mobile app with 400+ self-guided, interactive programs, live weekly therapist-led anonymous classes, on demand sessions and more. The App empowers couples, individuals, and parents to improve their mental health in as little as five minutes a day.

Self-Help Resources

Access to thousands of tools, videos, webinars, self-assessments, financial calculators and informative articles covering virtually every issue you might face, such as adoption, relationships, legal and financial matters, cancer and other illnesses, and more.

Work/Life Benefits

Assistance for financial and legal issues, child & elder care, LGBTQIA+ issues, military life, and more.

Personal Assistant

Help for everyday issues, including finding a local medical or dental provider, summer camp options, pet care, and more.

Wellness Benefits

Videos and resources to improve you and your family's overall health, including fitness, nutrition, diet, tobacco cessation, sleep health, and information on illnesses.

Lifestyle Savings Benefit

Thousands of discounts, rewards, and perks in a variety of categories: Health & Wellness, Auto, Electronics, Apparel, Restaurants, Beauty & Spa, Flowers & Gifts, Sports & Fitness and more! Benefits are accessible from ESI's Member website.

Contact the EAP toll-free at **800.252.4555.** All calls are **CONFIDENTIAL** and answered by a Masters or Ph.D. level counselor; your counselor will work with you on a plan beginning with the first call. Or go to **www.theEAP.com** and create a username and password.

Welcome to Health Navigator, powered by PinnacleCare



As a member, you have access to personal support for any healthcare challenge you are facing. Our team provides you access to top experts, and helps you navigate the complicated world of healthcare so you can have peace of mind, and focus on what really matters—your health.

Access Health Navigator for the confidence that you are making the right healthcare decisions for you and your family.

We specialize in providing access to top specialists, especially when you...

- Receive a new diagnosis
- Have a surgery recommendation
- Feel unsure of your doctor's medical advice
- Require a top healthcare specialist
- Want help to find a new primary care provider

When facing an unexpected healthcare challenge, our advisors will help you...

- Review your case
- Understand your condition
- Gather your medical records
- Understand your treatment options
- Schedule appointments
- Facilitate second opinions from experts
- Make informed decisions
- Achieve better health outcomes

Contact Health Navigator when you need access to a specialist, a new primary care doctor, or for any health-related need.
Visit **sunlife.com/healthnav** or call **888-352-4969**. Representatives are available Monday - Friday, 8:00am - 6:00pm (ET).

Group stop-loss insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 07-SL REV 7-12 and 22-SL. In New York, Group stop-loss insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 07-NYSL REV 7-12 and 22-NYSL. Policy offerings may not be available in all states and may vary due to state laws and regulations.

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GSLFL-10555-I

SLPC 31063 06/23 (exp. 06/25)

HEALTH NAVIGATOR, POWERED BY PINNACLECARE

Health Navigator: Personalized support for your medical journey

Your organization offers Health Navigator as a complimentary benefit to assist you with any medical concerns. This valuable resource provides professional advice and helps you navigate the complexities of the healthcare system.

We are here for you

A healthcare challenge can happen at any time, from a need for routine care to a serious diagnosis. When faced with medical concerns, Health Navigator is ready to assist you with a wide range of health needs, including:

Understanding your diagnosis

- Confirming your diagnosis
- Getting second opinions from expert doctors (online or in-person)

Planning your care

- Exploring the best treatment options
- Connecting you with the right doctors

Preventive care

- Creating a preventive care plan tailored to your needs

Choosing a doctor

- Finding doctors who are a good match for what you need
- Making sure your current doctors are the right ones for your health issues

Administrative assistance

- Setting up appointments
- Collecting and sending your medical records where needed

Health information and education

- Researching your health condition
- Answering your questions about your medical concerns

Did you know?

Health Navigator services are available at no cost for you and your eligible family members, including your parents/parents-in-law and your adult children, and always confidential.

Health Navigator is here to help you get answers and access the best care for your needs. Our Care Advisors and medical team are ready to support you. Our mission is to empower you with personalized guidance, ensuring you achieve optimal health outcomes and peace of mind.

Don't let health concerns overwhelm you. With Health Navigator by your side, you'll have:

- Expert support tailored to your unique needs
- Practical guidance to make well-informed choices
- A compassionate team committed to your well-being
- Expert negotiation of large medical bills over $800

Contact Health Navigator today and experience the difference of having a true healthcare advocate in your corner:

- Visit **sunlife.com/healthnav**
- Call **888-352-4969** (Mon-Fri, 8am-6pm ET)
- Download the **Sun Life Health 360 app** to chat live with a Care Advisor and get access to health and well-being tools and resources

omada for Cigna

For eligible Suffield Town & Board of Education employees and their covered dependents



Join Omada to build healthy habits that last

Omada® is a digital lifestyle change program. We combine the latest technology with ongoing support so you can make the changes that matter most—whether that's around eating, activity, sleep, or stress. It's an approach shown to help you lose weight and reduce the risks of type 2 diabetes and heart disease.

- **EAT HEALTHIER**
  Learn the fundamentals of making smart food choices.
- **INCREASE ACTIVITY**
  Discover easy ways to move more and boost your energy.
- **OVERCOME CHALLENGES**
  Gain skills that allow you to break barriers to change.
- **STRENGTHEN HABITS**
  Zero in on what works for you, and find lasting motivation.
- **STAY HEALTHY FOR LIFE**
  Continue to set and reach your goals with strategies and support.

MORE GREAT NEWS:

You'll receive the program at no additional cost if you or your adult dependents are enrolled in the Suffield Town & Board of Education medical plan offered through Cigna, are at risk for diabetes or heart disease, and are accepted into the program.

Take Omada's 1-minute health screener to see if you're eligible:

omadahealth.com/suffield

YOU'LL GET YOUR OWN:

- Interactive program
- Wireless smart scale
- Weekly online lessons
- Professional Omada health coach
- Small online group of participants

The Omada® program is administered by Omada Health, Inc., an independent third party service provider. All Cigna® products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company or its affiliates. The Omada® program is not administered by Cigna. It is administered solely by Omada Health, Inc. which is responsible for the program.

Teladoc® HEALTH

DIABETES MANAGEMENT PROGRAM

Healthier living made easier



Your health and the health of your family is important to your plan sponsor. With that in mind, the Diabetes Management program by Teladoc Health is now being offered **at no cost to you** so you can live your healthiest life and feel your best.

Tools and support, tailored to you:

Expert coaching
Coaches provide guidance and offer real-time support for out-of-range readings.

Unlimited strips
Get as many strips and lancets as you need, delivered right to your door.

A connected meter
The meter provides real-time tips and automatically uploads your blood sugar readings.

Get started today at no cost to you

Visit TeladocHealth.com/Register/SUFFIELD
or call Teladoc Health Member Support at 800-835-2362.

To enroll in Teladoc Health, you must opt in to at least one program that your plan sponsor offers as a health benefit. You must also meet the health criteria for each program you wish to enroll in. If a Teladoc Health program is not offered by your plan sponsor, or if you do not meet the specific health criteria of that program, you will not be able to enroll.

Las comunicaciones del programa Teladoc Health están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en es-pañol, llame al 800-835-2362 o visite TeladocHealth.com/Bienvenido/SUFFIELD

Program includes trends and support on your secure Teladoc Health account and mobile app but does not include a tablet or phone.

Program eligibility varies. Visit our website to learn more.

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SEARCHING FOR PARTICIPATING PROVIDERS

MEDICAL

Medical Provider Search:

1. Go to https://hcpdirectory.cigna.com/web/public/consumer/directory/search
2. Under “How are you Covered” select “Employer or School”
3. You must either enter an address, city, or zip code in the box on the next screen
4. Then choose a search category below the box, such as: “Doctor by Type”, “Doctor by Name” or “Health Facilities”
5. Enter the Type, Name, or Location you desire. You may be asked to filter your results for Primary Care Providers or Specialists
6. You will also be given the options to log in (requires you to resgister as a member) or select your plan
7. Select “Open Access Plus” as the plan name

VISION

Vision Provider Search:

1. Go to https://eyedoclocator.eyemedvisioncare.com/cigna/en
2. You can choose to search by location or by doctor or office name
3. Enter your zip code or allow the site to use your location

DENTAL

Dental Provider Search:

1. Go to https://hcpdirectory.cigna.com/web/public/consumer/directory/search
2. Under “How are you Covered” select “Employer or School”
3. You must either enter an address, city, or zip code in the box on the next screen
4. Then choose a search category below the box, such as: “Doctor by Type”, or “Doctor by Name”
5. Enter the Type, Name, or Location you desire.
6. You will also be given the options to log in (requires you to resgister as a member) or select your plan
7. Select “Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)” as the plan name

REGISTERING ONLINE TO ACCESS ID CARDS AND CLAIMS INFO

- Go to my.cigna.com/web/public/guest
- Log In or Register as a member

OR DOWNLOAD THE MYCIGNA MOBILE APP:

- Available for Android or I-Phone users
- Free to download
- Can store all your ID card information
- Search for providers, procedures, and cost estimates
- See recent claims and their status

COBRA

Continuation Coverage Rights Under COBRA

The Town of Suffield Health and Welfare Benefit Plans, including the Group Medical, Dental, Vision, and Flexible Spending Account plans are subject to COBRA regulations. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plans. The right to COBRA continuation coverage was created by a Federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plans when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to protect your right to receive it.** This notice gives you only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plans and under Federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document(s) from a Plan Administrator. Contact Information appears at the end of this notice.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event know as a "qualifying event". Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plans because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plans because either or of the qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

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

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse.

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

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding is filed with respect to The Town of Suffield, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plans, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plans.

When is COBRA Coverage Available?

The Plans will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in a bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

The Town of Suffield Human Resources Department

Appropriate documentation (such as a copy of the divorce decree) to prove you have experienced a qualified event much be attached.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event, or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

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

The qualified beneficiary must notify the Plan Administrator of receiving the disability determination: and

1. The latest of 60 days following:

Receipt of the determination,

The date of the qualifying event,

The date of loss of coverage, or

Receipt of explanatory notice of qualified beneficiary notice obligations; and

2. Prior to the end of the18-month period. The Social Security Disability Administration notice should be sent to:

The Town of Suffield

Second Qualifying Event Extension of 18-Month Period of Continuation of Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if notice of the second qualifying event is properly given to the Plans. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plans as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plans had the first qualifying event not occurred. **In all cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.** This notice must be sent to the Benefit Labor Team (888) 828 7762

Keep Your Plans Informed of Address Changes

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

If You Have Questions

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

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

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

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

PATIENT PROTECTION DISCLOSURE

Cigna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the member services department on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

WOMENS' HEALTH & CANCER RIGHTS ENROLLMENT ACT 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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Form Approved OMB No. 1210-0149
(expires 5-31-2027)

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 DSO if you are a school-based employee, or Team Talent Operations if you are a Network Support employee.

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.

[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.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)		12. Email address

Here is some basic information about health coverage offered by this employer:

•As your employer, we offer a health plan to:

X Some employees. Eligible employees:
(1) Work at least 30 hours per week
(2) Work 20 hours per week and have previously worked for at least 30 hours per week for at least one year
(3) or, are Temporary workers that work more than 90 days meeting the minimum hours

•With respect to dependents:

X We do offer coverage. Eligible dependents are:
An individual who is the son, daughter, stepson, or stepdaughter of the subscriber;
An individual who was legally adopted by the subscriber;
An individual who is placed with the subscriber for legal adoption by the subscriber;
A child for whom the subscriber is the court-appointed guardian; or
An eligible foster child (defined as an individual who is placed with the subscriber by an authorized placement agency or by judgment, decree, or other court order).
Domestic partner, same or opposite sex

✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? __ Yes (Continue) _ No (STOP and return this form to employee)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
__ Yes (Go to question 15) __No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? __ Weekly __Every 2 weeks __Twice a month
__ Monthly __Quarterly __ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
__ Employer won't offer health coverage
__ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? __ Weekly __Every 2 weeks __Twice a month
__ Monthly __Quarterly __ Yearly

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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

FAQS

PATIENT CARE ADVOCACY SERVICES

Sometimes dealing with an insurance company can be stressful. It may feel like they are speaking another language. Whether you have a question about your benefits or if you need help working with one of the insurance companies to ensure a claim is paid properly, our insurance broker MDG is here to help you.

This confidential service is available to you Monday-Friday, 8am to 5:30pm:

- Answer questions about your benefits
- Explain how to best use your plan
- Resolve claims and billing issues
- Clarify the total and out-of-pocket costs for services
- Assist with referrals and prior authorization
- Help with claim appeals
- Help you find a doctor or hospital

This service is completely free to you and your dependents and you are automatically enrolled when you participate in a Town of Suffield benefit plan. For assistance, contact MDG at 888-282-1591 or email Mybenefits@mdgbenefits.com

MDG
BENEFIT SOLUTIONS

Your benefit plan is supported by MDG Benefit Solutions
Mybenefits@mdgbenefits.com
888 282 1591 TOLL FREE
203 315 0510 FAX
www.mdgbenefits.com

GLOSSARY OF TERMS

• **Provider:** any doctor, clinic, hospital or lab that provides medical services.

• **Coverage**: what services are actually included in the medical plan.

• **Premiums:** the fixed amount of money that is withheld from every paycheck. This is the cost of being in

the plan and does not cover any services.

• **Co-pay:** the flat fee that is paid at every visit with a provider.

• **Deductible:** the amount of money you are responsible for first.

• **Co-insurance:** the split between insurance and you after you have met the deductible.

• **Out-of-Pocket Maximum:** the absolute maximum you will pay for services (co-pays OR deductible + coinsurance) in a plan year. This total does not include what you pay in premiums!

• **HRA:** Health Reimbursement Account – a plan that offers a way for your employer to “reimburse” some of your deductible

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0/individual or $0/family For out-of-network providers: $200/individual, $400/individual +1 or $500/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Out-of-network emergency room visits, out-of-network urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $50/individual home health care deductible for Out of Network Services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers $6,600/individual or $13,200/family For out-of-network providers $1,000/individual, $2,000/individual +1 or $2,500/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	20% coinsurance	None
	Specialist visit	$15 copay/visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs (Tier 1)	$5 copay/prescription (retail 30 days), $15 copay/prescription (retail 100 days); $3 copay/prescription (home delivery 100 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 100-day supply (retail and home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.cigna.com	Preferred brand drugs (Tier 2)	$10 copay/prescription (retail 30 days), $30 copay/prescription (retail 100 days); $3 copay/prescription (home delivery 100 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	$10 copay/prescription (retail 30 days), $30 copay/prescription (retail 100 days); $3 copay/prescription (home delivery 100 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	20% coinsurance	Per visit copay is waived for non-surgical procedures.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$25 copay/visit	$25 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits.
	Urgent care	$15 copay/visit	$15 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit No charge/all other services	20% coinsurance/office visit 20% coinsurance/all other services	Includes medical services for MH/SA diagnoses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	$200 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$200 copay/admission	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after the home health care deductible	Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	20% coinsurance/visit	Coverage is limited to annual max of: 50 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge/visit	20% coinsurance/visit	Habilitative Services are covered for Physical, Speech and Occupational Therapies subject to the same rehabilitative services limit above. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	$200 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 180 days annual max.
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge	No charge Deductible does not apply	Limited to 1 eye exam per 12 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery (in-network only) • Chiropractic care (combined with Rehabilitation Services)	• Hearing aids (2 devices per 24 months) • Infertility treatment	• Private-duty nursing ($15,000 maximum) • Routine eye care (Adult) (Limited to 1 eye exam per 12 months)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Connecticut Office of the Health Care Advocate at (866) 466-4446.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$220

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$340

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$100

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP1 Plan Ben Ver: 35 Plan ID: 38043738

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0/individual or $0/family For out-of-network providers: $400/individual, $800/individual +1 or $1,000/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Out-of-network emergency room visits, out-of-network urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $50/individual home health care deductible for Out of Network Services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers $6,600/individual or $13,200/family For out-of-network providers $1,800/individual, $3,600/individual +1 or $4,200/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services.If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20% coinsurance	None
	Specialist visit	$20 copay/visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs (Tier 1)	$5 copay/prescription (retail 30 days), $10 copay/prescription (retail 90 days); $10 copay/prescription (home delivery 90 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply,

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.cigna.com	Preferred brand drugs (Tier 2)	$15 copay/prescription (retail 30 days), $30 copay/prescription (retail 90 days); $30 copay/prescription (home delivery 90 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	including, for example: prior authorization, step therapy, quantity limits. For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	$20 copay/prescription (retail 30 days), $40 copay/prescription (retail 90 days); $40 copay/prescription (home delivery 90 days)	20% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	20% coinsurance	Per visit copay is waived for non-surgical procedures.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits.
	Urgent care	$20 copay/visit	$20 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit No charge/all other services	20% coinsurance/office visit 20% coinsurance/all other services	Includes medical services for MH/SA diagnoses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	$300 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$300 copay/admission	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after the home health care deductible	Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	20% coinsurance/visit	Coverage is limited to annual max of: 50 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge/visit	20% coinsurance/visit	Habilitative Services are covered for Physical, Speech and Occupational Therapies subject to the same rehabilitative services limit above. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	$300 copay/admission	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 180 days annual max.
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge	No charge Deductible does not apply	Limited to 1 eye exam per 12 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery (in-network only) • Chiropractic care (combined with Rehabilitation Services)	• Hearing aids (2 devices per 24 months) • Infertility treatment	• Private-duty nursing ($15,000 maximum) • Routine eye care (Adult) (Limited to 1 eye exam per 12 months)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Connecticut Office of the Health Care Advocate at (866) 466-4446.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$320

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$440

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$200

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP2 Plan Ben Ver: 35 Plan ID: 37891202

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $2,000/individual - employee only or $4,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $4,000/individual - employee only or $8,000/family maximum For out-of-network providers: $4,000/individual - employee only or $8,000/family maximum Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	20% coinsurance	None
	Specialist visit	No charge/visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	$5 copay/prescription (retail); $5 copay/prescription (home delivery)	20% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 34-day supply (retail) and a 100-day supply (home delivery). Certain limitations may apply, including, for example: prior

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at www.cigna.com	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail); $60 copay/prescription (home delivery)	20% coinsurance/prescription (retail); Not covered (home delivery)	authorization, step therapy, quantity limits. For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	$45 copay/prescription (retail); $90 copay/prescription (home delivery)	20% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	20% coinsurance/office visit 20% coinsurance/all other services	Lesser of 50% of covered expenses or $200 penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	20% coinsurance/visit	Coverage is limited to annual max of: 36 days for Cardiac rehab services
	Habilitation services	No charge/visit	20% coinsurance/visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Habilitative Services are covered for Physical, Speech and Occupational Therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 220 days annual max.
	Durable medical equipment	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Hospice services	No charge/inpatient services No charge/outpatient services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 eye exam per 12 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (in-network only)
- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 24 months)
- Infertility treatment
- Private-duty nursing ($15,000 maximum)
- Routine eye care (Adult) (Limited to 1 eye exam per 12 months)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Connecticut Office of the Health Care Advocate at (866) 466-4446.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,030

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$2,240

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA6 Plan Ben Ver: 35 Plan ID: 38043655

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $4,000/individual or $8,000/family For out-of-network providers: $4,000/individual or $8,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, prescription drugs, emergency room visits, in-network urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $5,000/individual or $10,000/family For out-of-network providers: $5,000/individual or $10,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	20% coinsurance	None
	Specialist visit	$45 copay/visit Deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition More information about	Generic drugs (Tier 1)	$10 copay/prescription (retail); $5 copay/prescription (home delivery) Deductible does not apply	20% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery); up to a 30-day supply (retail and home delivery) for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at www.cigna.com	Preferred brand drugs (Tier 2)	$25 copay/prescription (retail); $60 copay/prescription (home delivery) Deductible does not apply	20% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail); $90 copay/prescription (home delivery) Deductible does not apply	20% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	$350 copay/visit Deductible does not apply	$350 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits.
	Urgent care	$75 copay/visit Deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit** No charge/all other services **Deductible does not apply	20% coinsurance/office visit 20% coinsurance/all other services	Lesser of 50% of covered expenses or $200 penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$30 copay/PCP visit** $45 copay/ Specialist visit** **Deductible does not apply	20% coinsurance/PCP visit 20% coinsurance/ Specialist visit	Coverage is limited to annual max of: 36 days for Cardiac rehab services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$30 copay/PCP visit** $45 copay/ Specialist visit** **Deductible does not apply	20% coinsurance/PCP visit 20% coinsurance/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification. Coverage is limited to 220 days annual max.
	Durable medical equipment	No charge	20% coinsurance	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
	Hospice services	No charge/inpatient services No charge/outpatient services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Lesser of 50% of covered expenses or $200 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Limited to 1 eye exam per 12 months.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (in-network only)
- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 24 months)
- Infertility treatment
- Private-duty nursing ($15,000 maximum)
- Routine eye care (Adult) (Limited to 1 eye exam per 12 months)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Connecticut Office of the Health Care Advocate at (866) 466-4446.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$4,060

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$860

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist copayment	$45
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$980
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,580

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP Hybrid Plan Ben Ver: 35 Plan ID: 40068107

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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

cigna healthcare

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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