

Medical Plan Coverage: Plan year July 1, 2023-June 30, 2024

Quality First Select Access Plan

Here's how much you pay for covered services depending on where you choose to receive care.

| Benefit Features | Quality First Select Access | | |
|--|--|--|--|
| | In-Network Value Tier 1 | In-Network Tier 2 | Out-of-Network ¹ |
| Office visit ² | You pay \$0 | PCP: You pay \$50 Specialist: You pay \$100 | You pay 20%, plus deductible |
| LiveHealth Online (telemedicine) | You pay \$0 | N/A | N/A |
| Preventive care | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Walk-In Clinic/Urgent Care Center ³ | You pay \$35 | You pay \$35 | You pay 20%, plus deductible |
| Emergency care (waived if admitted) | You pay \$250 | You pay \$250 | You pay \$250 |
| Diagnostic lab | Site of Service | You pay \$0 | N/A |
| | Non-Site of Service | You pay 20% | You pay 40%, plus deductible |
| Diagnostic x-ray (prior authorization required for diagnostic imaging) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Inpatient physician/hospital (prior authorization required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Outpatient surgical facility (prior authorization required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Ambulance (if emergency) | You pay \$0 | You pay \$0 | You pay \$0 |
| Short-term rehabilitation and physical therapy (prior authorization may be required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Routine eye exam (one exam per year) | You pay \$0 | You pay \$50 ⁴ | You pay 50%, plus deductible |
| Audiology screening (one exam per year) | You pay \$0 | You pay \$50 | You pay 20%, plus deductible |
| Inpatient Mental Health/Substance Abuse (prior authorization required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Outpatient Mental Health/Substance Abuse | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Family planning: vasectomy or tubal ligation (prior authorization may be required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Durable medical equipment (prior authorization may be required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Skilled nursing facility (prior authorization required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Home health care (up to 200 visits per year; prior authorization required) | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Annual deductible | \$0 ⁵ | | Individual: \$500 ⁵ Family: \$1,500 ⁵ |
| Annual out-of-pocket maximum | Individual: \$3,000 Family: \$6,000 | | Individual: \$6,000 Family: \$12,000 |

¹ You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

² PCP telemedicine visits are covered the same as office visits.

³ Hartford Hospital Centers are considered out-of-network.

⁴ Health Enhancement Program participants have \$50 copay waived once every two years.

⁵ Non-HEP Compliant: Additional \$350 per individual; \$1,400 maximum per family

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All Other Medical Plans

Here's how much you pay for covered services depending on the plan you're enrolled in and where you choose to receive care.

| Benefit Features | | Primary Care Access Standard Access | Expanded Access State Preferred POS ¹ Out-of-Area | |
|--|---------------------|--|--|--|
| | | In-Network ONLY | In-Network | Out-of-Network ² |
| Office visit | | \$15 ^{***} | You pay \$15 ^{***} | You pay 20%, plus deductible |
| Walk-In Clinic/Urgent Care Center | | You pay \$15 | You pay \$15 | You pay 20%, plus deductible |
| LiveHealth Online (telemedicine) | | You pay \$5 | You pay \$5 | N/A |
| Preventive care | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Emergency care (waived if admitted) | | You pay \$250 | You pay \$250 | You pay \$250 |
| Diagnostic lab | Site of Service | You pay \$0 | You pay \$0 | N/A |
| | Non-Site of Service | You pay 20% | You pay 20% | You pay 40%, plus deductible |
| Diagnostic x-ray (prior authorization required for diagnostic imaging) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Inpatient physician/hospital (prior authorization required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Outpatient surgical facility (prior authorization required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Ambulance (if emergency) | | You pay \$0 | You pay \$0 | You pay \$0 |
| Short-term rehabilitation and physical therapy (prior authorization may be required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible; up to 60 inpatient days, 30 outpatient days per condition per year |
| Routine eye exam (one exam per year) | | You pay \$15 ³ | You pay \$15 ³ | You pay 50%, plus deductible |
| Audiology screening (one exam per year) | | You pay \$15 | You pay \$15 | You pay 20%, plus deductible |
| Inpatient Mental Health/Substance Abuse (prior authorization required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Outpatient Mental Health/Substance Abuse | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Family planning: vasectomy or tubal ligation (prior authorization may be required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Durable medical equipment (prior authorization may be required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible |
| Skilled nursing facility (prior authorization required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible; up to 60 days per year |
| Home health care (prior authorization required) | | You pay \$0 | You pay \$0 | You pay 20%, plus deductible; up to 200 visits per year |
| Annual deductible | | \$0 ⁴ | \$0 ⁴ | Individual: \$300 ⁴ Family: \$900 ⁴ |
| Annual out-of-pocket maximum | | Individual: \$2,000 Family: \$4,000 | Individual: \$2,000 Family: \$4,000 | Individual: \$2,000, plus deductible Family: \$4,000, plus deductible |

¹ Closed to new enrollments

² You pay coinsurance plus 100% of any amount your provider bills over the allowable charge.

³ Health Enhancement Program participants have \$15 copay waived once every two years.

⁴ Non-HEP Compliant: Additional \$350 per individual; \$1,400 maximum per family

^{***} \$0 copay for Value Tier 1 providers or for a HEP Chronic Condition visit

Dental Plan Coverage: Plan year July 1, 2023-June 30, 2024

| | Cigna Dental Care DHMO Plan | Total Care DHMO Plan | Enhanced Plan | Basic Plan |
|------------------------------------|-----------------------------|----------------------|---------------|--------------|
| Primary Care Dentist | Required | Required | Not Required | Not Required |
| Referred from Primary Care Dentist | Required | Required | Not Required | Not Required |
| In- and Out-of-Network Coverage* | No | No | Yes | Yes |
| What you pay when you get care | Copays | Coinsurance | Coinsurance | Coinsurance |

* When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist

Here's what you'll pay for covered dental services, depending on the plan you elect.

| | Cigna Dental Care DHMO Plan | Total Care DHMO Plan | Enhanced Plan | Basic Plan |
|---|-----------------------------|---|--|--|
| Annual deductible | None | None | Individual: \$25 Family: \$75 | None |
| Annual maximum | None | None | \$3,000 per person (excluding orthodontia) | None |
| Exams, cleanings and x-rays | Plan pays 100% | Plan pays 100% | Plan pays 100%, deductible does not apply ¹ | Plan pays 100% |
| Periodontal maintenance ² | Copay ³ | 15% coinsurance, plan pays 85% | Plan pays 100% ¹ | 20% (if enrolled in HEP, plan pays 100%) |
| Periodontal root scaling and planing ² | Copay ³ | 15% coinsurance, plan pays 85% | 20% | 50% |
| Other periodontal services | Copay ³ | 15% coinsurance, plan pays 85% | 20% | 50% |
| Simple Restoration | | | | |
| Fillings | Copay ³ | 15% coinsurance, plan pays 85% | 20% | 20% |
| Oral surgery | Copay ³ | 15% coinsurance, plan pays 85% | 20% | 33% |
| Major Restorations | | | | |
| Crowns | Copay ³ | 30% coinsurance, plan pays 70% | 33% | 33% |
| Dentures, fixed bridges | Copay ³ | 45% coinsurance, plan pays 55% | 50% | Not covered ⁴ |
| Implants | Copay ³ | 45% coinsurance, plan pays 55% (one per year) | 50% (plan pays benefits up to \$500) | Not covered ⁴ |
| Orthodontia | Copay ³ | 45% coinsurance, plan pays 55% | 50%, plan pays maximum of \$1,500 per person per lifetime ⁵ | Not covered ⁴ |

¹ In the Enhanced plan, use an in-network dentist to ensure your care is covered 100%; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.

² If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

³ Contact Cigna at 800-244-6224 for patient copay amounts.

⁴ While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 13 for details).

⁵ Benefits are prorated over the course of treatment.