

SUMMARY OF BENEFITS

Benefits outlined below are intended as a general summary and are covered only when using a Cigna Open Access Plus Network participating provider. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Plan year is defined from July 1 through June 30.

BENEFITS	GREEN OPEN ACCESS (In Network Benefits Only)
DEDUCTIBLES, MAXIMUMS Plan Year Deductible Coinsurance Out-of-Pocket Maximum/Plan Year (Medical) Out-of-Pocket Maximum/Plan Year (Prescription Drugs) Maximum Lifetime benefit	<p style="text-align: center;">PLAN MEMBER PAYS</p> \$0 20% (DME and EPA only) Individual: \$1,000; Family: \$2,000 Individual: \$2,000; Family: \$4,000 Unlimited <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> All copays and coinsurance contribute to the Out-of-Pocket Maximums. </div>
PREVENTIVE CARE <i>(Includes Naturopath Services, Routine Laboratory & Diagnostic Testing)</i> Routine Physical Examination Routine Immunizations Well Child Preventive Care Well Woman Preventive Care Adult Preventive Care Additional services such as urinalysis and EKG	\$0 \$0 \$0 \$0 \$0 \$0
ROUTINE VISION CARE Routine Exam (one every 12 months for all ages) Discounts Available for Eyewear	\$0
HEARING TESTS	\$10 per visit
OTHER PHYSICIAN SERVICES <i>(Includes Naturopath Services)</i> Office Visits and/or Office Surgery Maternity Care Telehealth Visit <i>(see details on myCigna.com)</i>	\$10 per visit \$10 per visit (initial visit only) \$10 per visit
OUTPATIENT DIAGNOSTIC TESTING Radiology and Laboratory Services (Prior authorization required for some tests)	\$0
HOSPITAL CARE Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies Newborn Care	\$0 (Inpatient admissions and some outpatient procedures require prior authorization)

BENEFITS	GREEN OPEN ACCESS (In Network Benefits Only)
EMERGENCY & URGENT CARE <i>(Medically Necessary and Worldwide)</i> Hospital Emergency Room Urgent Care Facility	\$50 per visit (waived if admitted) \$25 per visit (waived if admitted)
MENTAL HEALTH/SUBSTANCE USE DISORDER OUTPATIENT (Physician's office or Telehealth) INPATIENT HOSPITALIZATION AND OUTPATIENT FACILITY (Prior authorization required)	\$10 copay per visit \$0
PRESCRIPTION DRUGS Cigna Participating Pharmacies Go to Cigna.com/Rx90network for listing of 90-day network retail pharmacies Oral Contraceptives (generic) covered at \$0 copay (Prior authorization and step therapy are required for some drugs)	Retail - up to 90-day supply: \$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs Mail Order – up to 90-day supply: \$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs available through Express Scripts Home Delivery mail order Specialty Drugs: 30-day supply only, filled through Accredo Home Delivery mail order
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES OUTPATIENT: short-term rehab, up to 60 days per person/per plan year; includes PT, OT, ST and cardiac rehab (Combined maximum) INPATIENT (Prior authorization required)	\$10 per day \$0
CHIROPRACTIC CARE 20 days per person/per plan year	\$10 per day
ACUPUNCTURE* <i>(In or Out of Network)</i> 12 days per person/per plan year *Coverage based on Cigna's medical guidelines.	\$10 per day
DURABLE MEDICAL EQUIPMENT (DME)	20%
EXTERNAL PROSTHETIC APPLIANCES (EPA)	20%
OTHER BENEFITS ORAL SURGERY <i>(accidents only)</i> REMOVAL OF BONEY IMPACTED WISDOM TEETH COMPREHENSIVE INFERTILITY TREATMENT Go to managed.winfertility.com/schoolcare SKILLED NURSING CARE <i>(100 days maximum per person/per plan year)</i> AMBULANCE <i>(if not a true emergency, services are not covered)</i> BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	\$0 (\$10, Physician's office) \$0 (\$10, Physician's office) \$0 (\$10, Physician's office) \$0 \$0 \$0 \$0 \$0
EMPLOYEE ASSISTANCE PROGRAM	Included
GOOD FOR YOU! by SCHOOLCARE WELL-BEING INCENTIVES	Included – up to \$800 for subscriber and \$400 for spouse

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BENEFITS	RED OPEN ACCESS (In Network Benefits Only)
<p>DEDUCTIBLES, MAXIMUMS*</p> <ul style="list-style-type: none"> Plan Year Deductible (Medical) Coinsurance (Medical) Out-of-Pocket Maximum/Plan Year (Medical) Out-of-Pocket Maximum/Plan Year (Prescription Drugs) Maximum Lifetime Benefit <p>* No one person will incur more than the individual deductible/out-of-pocket maximum</p>	<p style="text-align: center;">YOU PAY</p> <ul style="list-style-type: none"> Individual: \$250; Family: \$500 20% Individual: \$1,000; Family: \$2,000 Individual: \$2,000; Family: \$4,000 Unlimited <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> <p>All copays and coinsurance contribute to the Out-of-Pocket Maximums.</p> </div>
<p>PREVENTIVE CARE <i>(Includes Naturopath Services, Routine Laboratory & Diagnostic Testing)</i></p> <ul style="list-style-type: none"> Routine Physical Examination Routine Immunizations Hearing Tests Well Child Preventive Care Well Woman Preventive Care Adult Preventive Care Additional services such as urinalysis and EKG Routine Eye Exam (one every 12 months for all ages) Discounts Available for Eyewear 	<ul style="list-style-type: none"> \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0
<p>OTHER PHYSICIAN SERVICES <i>(Includes Naturopath Services)</i></p> <ul style="list-style-type: none"> Office Visits and/or Office Surgery Maternity Care Telehealth Visit <i>(see details on myCigna.com)</i> 	<ul style="list-style-type: none"> Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
<p>OUTPATIENT DIAGNOSTIC TESTING</p> <ul style="list-style-type: none"> Radiology and Laboratory Services (Prior authorization required for some tests) 	<ul style="list-style-type: none"> Deductible, then 20% to the Out of Pocket Maximum
<p>HOSPITAL CARE</p> <ul style="list-style-type: none"> Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies Newborn Care 	<ul style="list-style-type: none"> Deductible, then 20% to the Out of Pocket Maximum <p>(Inpatient admissions and some outpatient procedures require prior authorization)</p>

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PRESCRIPTION DRUGS Cigna Participating Pharmacies Go to Cigna.com/Rx90network for listing of 90-day network retail pharmacies Oral Contraceptives (generic) covered at \$0 copay (Prior authorization and step therapy are required for some drugs)	Retail - up to 90-day supply: \$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs Mail Order – up to 90-day supply: \$0 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs available through Express Scripts Home Delivery mail order Specialty Drugs: 30-day supply only, filled through Accredo Home Delivery mail order
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES OUTPATIENT: short-term rehab, up to 60 days per person/per plan year, includes PT, OT, ST and cardiac rehab (combined maximum). INPATIENT (Prior authorization required)	Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
CHIROPRACTIC CARE 20 days per person/per plan year	Deductible, then 20% to the Out of Pocket Maximum
ACUPUNCTURE† (<i>In or Out of Network</i>) 12 days per person/per plan year †Coverage based on Cigna medical guidelines.	Deductible, then 20% to the Out of Pocket Maximum
DURABLE MEDICAL EQUIPMENT	Deductible, then 20% to the Out of Pocket Maximum
EXTERNAL PROSTHETIC APPLIANCES	Deductible, then 20% to the Out of Pocket Maximum
OTHER BENEFITS ORAL SURGERY (<i>accidents only</i>) REMOVAL OF BONEY IMPACTED WISDOM TEETH COMPREHENSIVE INFERTILITY TREATMENT Go to managed.winfertility.com/schoolcare SKILLED NURSING CARE (<i>100 days per person/per plan year maximum</i>) AMBULANCE (<i>if not a true emergency, services are not covered</i>) BLOOD TRANSFUSIONS HOME HEALTH SERVICES HOSPICE	All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.
EMPLOYEE ASSISTANCE PROGRAM	Included
GOOD FOR YOU! by SCHOOLCARE WELL-BEING INCENTIVES	Included – up to \$800 for subscriber and \$400 for spouse