CLARK ATLANTA UNIVERSITY

PLANS OF MEDICAL/PRESCRIPTION DRUGS, DENTAL & VISION *EFFECTIVE 1/1/2024*

Preferred Provider Organization (Cigna OAP Select) – A list of the Providers is available on the internet at www.Cigna.com

Telehealth Provider – A covered person may utilize MDLive Online via their myCigna App or https://www.mdlive.com

Timely Filing - A claim must be made no later than one year from the date of service

BENEFITS	PLAN A Medical/Rx/Dental/Vision	PLAN B Medical/Rx/Dental/Vision
MEDICAL WITH PRESCRIPTION DRUGS		
Type of Plan	Cigna Open Access POS OAP5 1000/20%/4000	Cigna Open Access POS OAP5 500/20%/3000
National network of physicians, hospitals, and ancillary services	Cigna Open Access POS	Cigna Open Access POS
Annual Limit on Essential Health Benefits	Unlimited	Unlimited
Primary Care Physician referral required	NO – in or out of network	NO – in or out of network
In-network deductible per year/person	$1,000 individual / $2,000 family	$500 individual / $1,000 family
Out-of-network deductible per year	$1,500 individual / $3,500 family	$1,000 individual / $2,000 family
In-network co-insurance (Including medical copays and prescription copays)	80% paid by plan after deductible with maximum out of pocket expense per person per year of $4,000 ($8,000 per family)	80% paid by plan after deductible with maximum out of pocket expense per person per year of $3,000 ($7,000 per family);
Out-of-network co-insurance (Including deductible and medical copays)	50% with maximum out of pocket expense per person per year of $8,500 per person ($21,500 per family)	50% with maximum out of pocket expense per person per year of $6,500 per person ($18,000 per family)
In-network physician office visits and related diagnostic x-ray and laboratory expenses	$40 copay for each primary or specialist visit with balance paid @ 100%	$35 copay for each primary or specialist visit with balance paid @ 100%
Out-of-network physician office visits	Plan pays 50% after satisfaction of deductible	Plan pays 50% after satisfaction of deductible
In-network hospital charges (in or out-patient)	Plan pays 80% after satisfaction of deductible	Plan pays 80% after satisfaction of deductible
In-network surgery and related expenses (in or out-patient)	Plan pays 80% after satisfaction of deductible	Plan pays 80% after satisfaction of deductible
Out-of-network surgery and related expenses (in or out-patient)	Plan pays 50% after satisfaction of deductible	Plan pays 50% after satisfaction of deductible
In-network Wellness and Routine Care (adult and child)	Plan pays 100% (deductible does not apply)	Plan pays 100% (deductible does not apply)
Out-of-Network Wellness and Routine Care (adult and child) (See pg. 2)	Plan pays 50% after satisfaction of deductible	Plan pays 50% after satisfaction of deductible
In-Network Diagnostic Lab & X-Ray	Plan pays 80% after satisfaction of deductible	Plan pays 80% after satisfaction of deductible
Emergency Room	$250 copay per visit to in or out-network facility (waived if admitted)	$250 copay per visit to in or out-network facility (waived if admitted)
Chiropractic Treatment 50 visits per calendar year	20% coinsurance after deductible is met or 50% coinsurance after deductible is met (Non-Network)	20% coinsurance after deductible is met or 50% coinsurance after deductible is met (Non-Network)
Acupuncture Treatment 50 visits per calendar year	20% coinsurance after deductible is met or 50% coinsurance after deductible is met (Non-Network)	20% coinsurance after deductible is met or 50% coinsurance after deductible is met (Non-Network)
Retail Health Clinic	$15 copay per visit deductible does not apply or 50% coinsurance after deductible is met (Non-Network)	$10 copay per visit deductible does not apply or 50% coinsurance after deductible is met (Non-Network)
Live Health Online through Sydney Mobile app (Covered employees, dependent spouses, and dependent children through Live Health Online)	$0 copay for each consultation with balance paid @ 100% for the first 12 visits then at PCP copay.	$0 copay for each consultation with balance paid @ 100% for the first 12 visits then at PCP copay.
Prescription Drugs *(Copays apply to the out-of- pocket maximum for prescription drugs)* Out-of-Pocket Maximum for Prescription Drugs	$3,000	
Retail	$10 generic / $30 preferred / $60 non-preferred (30-day supply) $30 generic / $90 preferred / $180 non-preferred (90-day supply)	
Mail Order	$25 generic / $75 preferred / $150 non-preferred (90-day supply)	
Specialty Drugs	25% of prescription cost up to maximum of $250 per prescription	

This information is intended to be a brief summary of our benefit program and is not interpreted as the official benefit plan document. In case of discrepancy, the summary plan description shall govern.

Preventive services are covered with no cost share if an In-Network Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, available at http://www.ahrq.gov/;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at http://www.cdc.gov/vaccines/acip/index.html;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at https://www.healthcare.gov/preventive-care-children/; and
- With respect to women, preventive care and screening provided by the Health Resources and Services Administration, available at http://www.hrsa.gov/ and the expanded women's preventive services, available at http://www.hrsa.gov/womensguidelines/. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share. For a list of covered preventive services, please visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

This Plan treats Mental or Nervous Disorders as any other illness. For benefits, please check the provider who is performing the services.

CIGNA DENTAL BENEFITS	PLAN A AND PLAN B
Calendar Year Deductible - Single / Family	**$50 / $150**
Calendar Year Maximum Benefit for Persons - Age 19 and Over (Excluding orthodontia) - Under Age 19	**$5,000** **No Maximum**
Lifetime Maximum Benefit for Orthodontia	**$2,000**
Class I – Diagnostic and Preventive Procedures	**100% (Deductible waived)**
Class II – Basic Procedures - Basic Restorative, Endodontics, Periodontics, Oral Surgery	**80% (after deductible)**
Class III – Major Procedures - Major Restorative, Prosthetics, Prosthetic Repairs and Adjustments	**50% (after deductible)**
Class IV-Orthodontia (Adult and child)	**50% (after deductible)**

A list of the Connection Dental Providers included in the PPO will be available at https://hcpdirectory.cigna.com/ or by calling (800) 997-1654.

CIGNA VISION BENEFITS	IN NETWORK	OUT OF NETWORK
Routine Eye Exam (1x per 12 months)	**$0 copay**	**Up to $42 reimbursement**
Eyeglasses Frames (1x per 12 months)	**$200 allowance, then 20% off any balance**	**Up to $45 reimbursement**
Eyeglasses Lenses (1x per 12 months) - Single vision lenses - Bifocal lenses - Trifocal lenses **Eyeglass Lens Enhancements** - Transitions Lenses (child under age 19) - Standard polycarbonate (child under age 19) - Factory scratch coating	 **$15 copay** **$15 copay** **$15 copay** **$0 copay** **$0 copay** **$0 copay**	 **Up to $40 reimbursement** **Up to $60 reimbursement** **Up to $80 reimbursement** **No allowance when obtained out-of-network**
Contact Lenses (1x per 12 months) ***(Instead of Eyeglass Lenses)*** - Elective conventional (non-disposable); OR - Elective disposable; OR - Non-elective (medically necessary)	 **$200 allowance, 15% off any balance** **$200 allowance (no additional discount)** **Covered in full**	 **Up to $105 reimbursement** **Up to $105 reimbursement** **Up to $210 reimbursement**

MONTHLY PRE-TAX PAYROLL DEDUCTIONS PER EMPLOYEE (MEDICAL/PRESCRIPTIONS/DENTAL/VISION)				
Coverage Type Selected	**PLAN A**		**PLAN B**	
	12-month employees	**9-month employees**	**12-month employees**	**9-month employees**
Employee only	**$132.97**	**$177.30**	**$272.36**	**$363.15**
Employee with Child(ren)	**$207.24**	**$276.33**	**$400.08**	**$533.45**
Employee with Spouse	**$233.47**	**$311.29**	**$462.09**	**$616.12**
Employee with Family	**$356.81**	**$475.75**	**$679.09**	**$905.46**