

Boehringer Ingelheim USA Corporation
Cigna Medical Plan Comparison- 2027 Plan Year

	CIGNA OAP		CIGNA HSA	
	IN-NETWORK	OUT-OF-NETWORK Subject to Reasonable and Customary (R&C) charges.	IN-NETWORK	OUT-OF-NETWORK Subject to Reasonable and Customary (R&C) charges.
Service Area	In-network coverage is available throughout the U.S. Specific provider information can be found by accessing "Find a Doctor" on www.cigna.com . Search under the 'OAP' network.			
Boehringer Annual Contributions to the Health Savings Account (HSA) Pro-rated for new hires and any new enrollments during the year. You can offset the deductible by using your HSA, which includes a dollar amount contributed by Boehringer.	N/A		Employee Only: \$500 Employee + Child(ren): \$1,000 Employee + Spouse/DP: \$1,000 Employee + Spouse/DP & Child(ren): \$1,000 <i>You may also contribute to the HSA pre-tax and/or after-tax, if elected, up to the IRS contribution limits. One family member or any combination of family members can use fund amounts. Please also note that due to IRS guidelines, dependents who are not tax dependents do not have access to these funds.</i>	
Garner Reimbursement	Employee Only: \$1,000 Employee + Child(ren): \$2,000 Employee + Spouse/DP: \$2,000 Employee + Spouse/DP & Child(ren): \$2,000 Paid via check.		Employee Only: \$1,000 Employee + Child(ren): \$2,000 Employee + Spouse/DP: \$2,000 Employee + Spouse/DP & Child(ren): \$2,000 Deposited into your HSA.	
Annual Deductible	Employee Only: \$1,000 Employee + Child(ren): \$2,000 Employee + Spouse/DP: \$2,000 Employee + Spouse/DP & Child(ren): \$2,000	Employee Only: \$2,000 Employee + Child(ren): \$4,000 Employee + Spouse/DP: \$4,000 Employee + Spouse/DP & Child(ren): \$4,000 <i>Family members meet only their \$1,000 individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</i>	Employee Only: \$2,000 Employee + Child(ren): \$4,000 Employee + Spouse/DP: \$4,000 Employee + Spouse/DP & Child(ren): \$4,000	Employee Only: \$4,000 Employee + Child(ren): \$8,000 Employee + Spouse/DP: \$8,000 Employee + Spouse/DP & Child(ren): \$8,000 <i>All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.</i>
Coinsurance	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Annual Out of Pocket Maximum Includes deductible.	Employee Only: \$3,000 Employee + Child(ren): \$6,000 Employee + Spouse/DP: \$6,000 Employee + Spouse/DP & Child(ren): \$6,000 Additional \$1,250 per person annual prescription out-of-pocket maximum for both retail medications and mail-order combined	Employee Only: \$4,000 Employee + Child(ren): \$8,000 Employee + Spouse/DP: \$8,000 Employee + Spouse/DP & Child(ren): \$8,000	Employee Only: \$4,000 Employee + Child(ren): \$8,000 Employee + Spouse/DP: \$8,000 Employee + Spouse/DP & Child(ren): \$8,000	Employee Only: \$8,000 Employee + Child(ren): \$16,000 Employee + Spouse/DP: \$16,000 Employee + Spouse/DP & Child(ren): \$16,000
Lifetime Maximum Coverage	Unlimited		Unlimited	
Pre-existing Condition Limitation	None		None	

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Prescription Drugs Retail and Home Delivery Applies to generic, preferred and non-preferred brand drugs. Certain medications may require preauthorization. Coverage for retail or home delivery medications is provided by CVS Caremark. Covered drug lists are available on Caremark.com: Performance Drug List Maintenance Drug List Preventive Drug List The third time you fill ongoing/maintenance drugs at a 30 day supply instead of a 90 day supply, you will be required to pay two times the regular coinsurance (or minimum copay) amount for a 30 day supply.	\$1,250 per person annual out-of-pocket maximum for retail and mail-order combined. 30 day supply at a participating pharmacy: Plan pays 80% coinsurance. You pay 20% or \$10 minimum copay (if actual cost of drug is less than \$10, then lesser amount applies). 90 day supply at a CVS Pharmacy or through CVS Caremark Mail Service: \$30.00 copay Boehringer brand medications: No cost (retail & home delivery) Specialty medications: \$30.00 copay Limited to 31-day supply per fill	Full cost will be due at the time of prescription fulfillment. Reimbursement based on in-network coverage is available after claim submission.	The medical plan deductible must be met before the prescription drug coverage outlined below applies, except for certain preventive medications. 30 day supply at a participating pharmacy: Plan pays 80% coinsurance. You pay 20% coinsurance or \$10 minimum copay (if actual cost of drug is less than \$10, then lesser amount applies) after deductible. 90 day supply at a CVS Pharmacy or through CVS Caremark Mail Service: \$30.00 copay after deductible Boehringer brand medications: No cost (retail & home delivery) after deductible Specialty medications: \$30.00 copay after deductible Limited to 31-day supply per fill	Full cost will be due at the time of prescription fulfillment. Reimbursement based on in-network coverage is available after claim submission.
Office Visits	Primary Care: \$35 Copay Specialists: \$50 Copay	70% after deductible	80% after deductible	60% after deductible
X-ray & Lab	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Preventive Care – Periodic Exams, including Gynecological, Well Baby/Child Care, Skin Cancer Screenings, Immunizations Providers may bill for non-routine services as well at time of preventive visit; these are subject to deductible, coinsurance, or copays.	100% no deductible	70% after deductible	100% no deductible	60% after deductible
Preventive Care – Routine Mammography Covered for females age 40 and above. Covered at earlier ages if medically necessary.	100% no deductible for first visit	70% after deductible	100% no deductible for first visit	60% after deductible
Preventive Care – Routine Annual Digital Rectal Exam (DRE) and Prostate Antigen Test (PSA) Covered for men ages 45 and older or age 40 with risk factors.	100% no deductible for first visit	70% after deductible	100% no deductible for first visit	60% after deductible

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Preventive Care – Colonoscopy/Sigmoidoscopy Limited to one colonoscopy every 10 years after age 45 and one sigmoidoscopy every 5 years after age 45.	100% no deductible	70% after deductible	100% no deductible	60% after deductible
Preventive Care – Routine Hearing Exam	100% no deductible	70% after deductible	100% no deductible	60% after deductible
Hearing Aids Up to \$2,000 per calendar year.	90% after deductible,	70% after deductible	80% after deductible	60% after deductible
Emergency Care	90% after deductible	Same as in-network	80% after deductible	Same as in-network
Urgent Care	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Ambulance	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Inpatient Hospital and Outpatient Surgery Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Mental Health & Substance Use Services (Inpatient)	100% after deductible	70% after deductible	100% after deductible	60% after deductible
Mental Health & Substance Use Service (Outpatient)	\$35 Copay	70% after deductible	100% after deductible	60% after deductible
Acupuncture	\$50 Copay	70% after deductible	80% after deductible	60% after deductible
Chiropractic Care/Spinal Manipulation Maximum of 60 visits per calendar year.	\$50 Copay	70% after deductible	80% after deductible	60% after deductible
Short-term Rehabilitation (includes physical, occupational, and speech therapy) Maximum of 60 visits per therapy type per calendar year.	\$50 Copay	70% after deductible	80% after deductible	60% after deductible
Infertility Services Coverage for diagnosis and treatment of the underlying medical condition. \$60,000 medical lifetime maximum.	90% after deductible	Not Covered	80% after deductible	Not Covered
Home Health Care Maximum of 80 visits per calendar year.	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Skilled Nursing Maximum of 60 days per calendar year.	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Hospice Care	90% after deductible	70% after deductible	80% after deductible	60% after deductible
For out-of-network services, a \$500 penalty will apply for failure to pre-certify. Pre-certification is member-initiated for out-of-network services.				
All maximums apply to in-network and out-of-network services combined				
This comparison is intended as a highlight of the various medical coverages offered to you as an employee of Boehringer Ingelheim. The actual plan documents and/or contracts contain complete plan provisions and govern the operation of the plans and payment of all benefits.				
As of 9/11/2026				