Employer Name: Upward Health National LLC
Employer State of Situs: New York
Name of Issuer: Cigna Health and Life Insurance Company
Plan Marketing Name: High PPO
Plan Year: Effective July 1, 2026 (Contract Year beginning July 1)
Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	**Employer Plan Covered Benefit? (Yes / No / Yes-with-limitation)**
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes Dental Care limited to charges for a continuous course of dental treatment for an Injury to teeth (accidental injury). Plan deductible and coinsurance applies. Covered same as any medical service based on place of service.
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes Allergy Treatment/Injections and Allergy Serum covered whether dispensed by Primary Care or Specialty Care Physician.
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No EXCLUDED. General exclusions expressly exclude hearing aids, 'including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs).' Benchmark covers bone anchored hearing aids and hearing aids for children; this plan does not. DISCREPANCY vs. benchmark.

4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes Durable Medical Equipment (including External Prosthetic Appliances) covered; Lifetime & Contract Year Maximum: Unlimited. Excludes microprocessor-controlled / myoelectric / power-enhanced devices.
5	Hospice	Ambulatory	Pg. 28	Yes-with-limitation Hospice covered. Life expectancy of twelve (12) or fewer months. Inpatient and Outpatient (outpatient at Home Health Care coinsurance level); Plan deductible/coinsurance applies. Lifetime Maximum: Unlimited. Excludes family-member services and services primarily aiding daily living.
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes-with-limitation Infertility Services covered: diagnosis and treatment once infertility is diagnosed, incl. injectable fertility drugs, IUI/artificial insemination, ART/IVF. Treatment Per Lifetime Maximum: Unlimited. Plan deductible/coinsurance applies. Oral fertility drugs covered under Pharmacy. EXCLUDES: reversal of voluntary sterilization; donor charges/eggs/sperm/embryos; fertility preservation (retrieval, cryopreservation, storage); surrogacy services. NOTE: Benchmark (Pgs. 23-24) provides more specific mandated infertility terms (up to 4-6 completed oocyte retrievals). Plan says 'treatment approach limited to least invasive and lowest cost' — verify parity with IL mandate.
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes Outpatient Facility Services (Operating/Recovery/Procedure/Treatment/Observation Room) covered; Plan deductible/coinsurance applies. Ambulatory Surgical Facility services covered.
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes Outpatient Professional Services (Surgeon; Radiologist, Pathologist, Anesthesiologist) covered; Plan deductible/coinsurance applies.
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes-with-limitation Private duty nursing covered only under the Home Health Care Services provision (outpatient private nursing included when approved as Medically Necessary). Home Health Care Contract Year Maximum: 40 visits. Inpatient private duty nursing is EXCLUDED. Visit = 2 hours or less; max 16 hours/day.
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes-with-limitation Prosthetics/Orthotics covered as External Prosthetic Appliances and Devices (prostheses, orthoses/orthotic devices, braces, splints) and Internal Prosthetic/Medical Appliances. Plan deductible /coinsurance applies. EXCLUDES external/internal power enhancements, microprocessor-controlled, and myoelectric prostheses/orthoses.

11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes Surgical Sterilization Procedure for Vasectomy covered (excludes reversals), based on place of service. Men's family planning, counseling, testing and sterilization covered.
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes-with-limitation TMJ surgical and non-surgical treatment covered; based on place and type of service. Contract Year & Lifetime Maximum: Unlimited. ALWAYS EXCLUDES appliances and orthodontic treatment.
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes Hospital Emergency Room covered; Plan deductible/coinsurance applies. Includes MH/SUD emergency (Ambulance for MH/SUD payable under ER section). Out-of-network Emergency Services covered at in-network cost share.
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes Ambulance covered; Plan deductible/coinsurance applies. Air Ambulance covered; Plan deductible/coinsurance applies. Non-emergency ambulance excluded except to nearest facility that can provide needed care.
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes-with-limitation Obesity Treatment: medical and surgical services for treatment/control of clinically severe (morbid) obesity covered (BMI >=40, or 35-39 with comorbidities per NHLBI). EXCLUDES cosmetic alteration of results and weight loss programs/treatments.
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes Breast Reconstruction and Breast Prostheses following mastectomy covered: reconstruction of affected breast, symmetry surgery on non-diseased breast, postoperative prostheses, mastectomy bras (lowest cost alternative), and treatment of physical complications incl. lymphedema.
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes-with-limitation Reconstructive Surgery covered to repair/correct a severe physical deformity or disfigurement accompanied by functional deficit (other than jaw/TMJ), when it restores/improves function, follows Medically Necessary non-cosmetic surgery, or is performed prior to age 19 for congenital absence/agenesis. Cosmetic surgery otherwise excluded.
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes-with-limitation Inpatient Hospital Facility Services covered; Plan deductible/coinsurance applies. Room & Board limited to semi-private negotiated rate (private room limited to semi-private rate); ICU/CCU limited to negotiated rate.

19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes-with-limitation Skilled Nursing Facility (Inpatient Services at Other Health Care Facilities) covered; Plan deductible then 80%. Contract Year Maximum: 60 days for Skilled Nursing Facility.
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes-with-limitation Transplant Services and Related Specialty Care covered (all medically appropriate, non-experimental transplants). Inpatient facility/professional services covered at Plan deductible/coinsurance applies at Cigna LifeSOURCE Transplant Network facilities. Lifetime Travel Maximum: $10,000 per transplant (only when using LifeSOURCE facilities). NOTE: Out-of-network transplant services listed as Not Covered.
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes Diagnostic Services covered: Laboratory Services and Radiology Services in PCP/Specialist office, outpatient hospital and independent lab facility; Plan deductible/coinsurance applies. Advanced Radiological Imaging (MRI/MRA/CT/PET/Nuclear) covered.
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	**Flag - Not clearly addressed** **The plan does not expressly itemize an intranasal opioid reversal agent (e.g., naloxone) associated with opioid prescriptions. Naloxone is generally covered as a Prescription Drug Product per the Drug List and Preventive Care (federally required preventive meds at 100%), but the specific IL benchmark mandate language (Pg. 32) is not reproduced. VERIFY against Prescription Drug List / plan sponsor confirmation.**
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes Mental (Behavioral) Health Treatment covered. Inpatient (Acute Inpatient & Residential Treatment) Plan deductible/coinsurance applies, Contract Year Maximum: Unlimited. Outpatient office visits and all other services (Partial Hospitalization, IOP, ABA, TMS) covered; Contract Year Maximum: Unlimited. Direct access to participating providers.
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	**Flag - Not clearly addressed** **The plan covers Substance Use Disorder treatment broadly (see item 25), which encompasses medication management, but does not reproduce the specific IL Opioid Medically Assisted Treatment (MAT) mandate language (no prior authorization, dispensing limits, fail-first, or lifetime limits on buprenorphine products). No reference to 'MAT' or 'buprenorphine' found. VERIFY MAT parity with IL mandate (Pg. 21).**

25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes Substance Use Disorder covered. Inpatient (Acute Detoxification, Acute Inpatient Rehabilitation, Residential Treatment) Plan deductible/coinsurance applies, Contract Year Maximum: Unlimited. Outpatient office visits and all other services (Outpatient Detoxification, Partial Hospitalization, IOP) covered; Contract Year Maximum: Unlimited.
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes Tele-Psychiatry / virtual behavioral care covered: MDLIVE Behavioral Services and Virtual Physician Services deliver MH/SUD consultations via video/telephone/internet; Plan deductible/coinsurance applies. Direct access to participating providers.
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	**Flag - Not clearly addressed** **The plan covers Prescription Drug Products on the Drug List generally, but does not reproduce the specific IL mandate for topical anti-inflammatory acute and chronic pain medication (e.g., Ketoprofen, Diclofenac). No specific reference found. VERIFY coverage/tier on the Prescription Drug List (benchmark Pg. 32).**
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No Pediatric dental is NOT provided under this Cigna medical plan. The plan's Dental Care benefit is limited to a continuous course of treatment for an Injury to teeth (accidental injury) only. Comprehensive pediatric dental EHB is provided via the separate stand-alone AllKids Pediatric Dental (DentaQuest of Illinois, LLC) document. Confirm the stand-alone pediatric dental plan is offered alongside this medical plan.
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No Pediatric Vision is NOT covered under this medical plan. General exclusions expressly exclude eyeglass lenses/frames, contact lenses and associated exams/fittings (except initial set after keratoconus treatment or cataract surgery) and routine refractions. Benchmark provides a pediatric vision benefit (Pgs. 26-27) through age 19; this plan does not. DISCREPANCY vs. benchmark — confirm whether pediatric vision is provided through a separate stand-alone plan.
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes Maternity Care Services covered: initial visit to confirm pregnancy, prenatal/postnatal visits and delivery (global maternity fee), and facility delivery (Inpatient Hospital, Birthing Center); Plan deductible/coinsurance applies. Newborn coverage and hospital maternity stay (48 hrs vaginal / 96 hrs cesarean) provided per Federal Requirements section.

31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes-with-limitation Outpatient Prescription Drugs covered via 3-tier Prescription Drug List. 30-day retail: 90-day retail/home delivery copays higher. Subject to Prior Authorization, Step Therapy, and Supply Limits. Certain specialty drugs home-delivery only. Federally-required preventive meds at 100%.
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes Colorectal Cancer screening covered as Preventive Care (USPSTF A/B recommendations) at 100% in-network. Diagnostic (non-routine) colonoscopy covered subject to place-of-service benefit.
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes Contraceptive/Birth Control Services covered at 100%: contraceptive devices (e.g., Depo-Provera, IUDs), diaphragms (in office), and women's sterilization (e.g., tubal ligations, excluding reversals). FDA-approved contraceptives per HRSA guidelines. Oral contraceptives covered under Pharmacy.
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	**Flag - Not clearly addressed** **Diabetes Self-Management Training and Education is not itemized as a distinct benefit line. Plan covers Nutritional Counseling when diet is part of medical management of a condition, and Medically Necessary foot care for diabetes. The discrete IL-mandated diabetes self-management training/education benefit (benchmark Pgs. 11 & 35) is not expressly stated. VERIFY coverage.**
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes-with-limitation Diabetic supplies: Plan covers test strips referenced under Home Health / supplies; insulin covered under Pharmacy (Patient Assurance Program — insulin not subject to deductible). NOTE: General DME/supplies exclusion excludes test strips 'except as specified' — the specific IL list of diabetic supplies (benchmark Pgs. 31-32) is not fully reproduced. VERIFY full diabetic-supply list coverage under Pharmacy/DME.
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes Mammography covered as Preventive Care (routine mammograms) at 100% in-network. Diagnostic (non-routine) mammograms covered subject to x-ray & lab benefit based on place of service.
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes Osteoporosis / Bone Mass Measurement covered as Preventive Care per USPSTF A/B recommendations at 100% in-network.

38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes Pap tests, PSA (prostate-specific antigen) testing and related cancer screening covered as Preventive Care (routine) at 100%; screening PSA testing expressly covered. Ovarian cancer surveillance covered subject to preventive/diagnostic status.
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes Preventive Care Services covered at 100% in-network per USPSTF (A/B), ACIP immunizations, HRSA women's/infant/child guidelines and Bright Futures/AAP periodicity schedule. Contract Year Maximum: Unlimited.
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes Women's Sterilization Procedures (e.g., tubal ligations, excluding reversals) covered at 100% under Contraceptive Coverage / Family Planning.
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes-with-limitation Chiropractic Care Services covered (office setting; conservative management of acute neuromusculoskeletal conditions via manipulation); Plan deductible/coinsurance applies. Contract Year Maximum: 30 visits; Lifetime Maximum: Unlimited. Osteopathic Manipulation covered under Outpatient Therapy Services. Chiropractic care not provided in an office setting is excluded.
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes-with-limitation Habilitative and Rehabilitative Services covered as part of a program of treatment to restore ('rehabilitative') or improve/adapt/attain ('habilitative') function, incl. congenital abnormality and MH/SUD conditions (e.g., autism, intellectual disability, developmental delay). Outpatient PT Contract Year Max: 60 visits; Speech/Hearing/Occupational Therapy Contract Year Max: 30 visits; Cardiac Rehab (Phase II only) Contract Year Max: 36 visits. EXCLUDES sensory integration therapy, dyslexia treatment, maintenance/preventive therapy, vitamin therapy.

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Legend & Notes

Yes = Benefit is covered by the employer plan.

No = Benefit is not covered / expressly excluded by the employer plan (see notes; flags a discrepancy vs. the IL benchmark).

Yes-with-limitation = Covered but subject to visit caps, dollar limits, age restrictions, or other conditions quoted from the plan.

Flag – Not clearly addressed = The plan does not clearly cover or exclude the benchmark item; requires verification against the Prescription Drug List or plan sponsor.

Source plan document: 650504_1_1186779_F_070126.pdf (Cigna Open Access Plus, HDHPQ OAPIN). Compared against IL Benchmark Plan (IL_BMP.pdf) and AllKids Pediatric Dental (IL_AllKids_Dental_Plan.pdf).

Key discrepancies vs. benchmark: (3) Bone anchored / hearing aids EXCLUDED; (29) Pediatric Vision EXCLUDED; (28) Pediatric Dental only via separate stand-alone plan.

Items flagged for verification: (22) intranasal opioid reversal agent; (24) Opioid MAT mandate terms; (27) topical anti-inflammatory pain medication; (34) diabetes self-management training/education; (35) full diabetic-supply list.