



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at [www.cigna.com/sp](http://www.cigna.com/sp). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	For <a href="#">in-network providers</a> : \$500/individual or \$1,500/family For <a href="#">out-of-network providers</a> : \$750/individual or \$2,250/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, inpatient hospital facility, outpatient hospital facility, <a href="#">prescription drugs</a> , emergency room visits, <a href="#">urgent care</a> facility visits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other <a href="#">deductibles</a> for specific services?</a>	Yes. \$125 for in-network outpatient hospital visit; \$250 for out-of-network outpatient hospital visit; \$250 per admission for in-network hospital stay; \$500 per admission for out-of-network hospital stay There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<a href="#">What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</a>	For <a href="#">in-network providers</a> : \$3,000/individual or \$6,000/family For <a href="#">out-of-network providers</a> : \$9,000/individual or \$18,000/family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the <a href="#">out-of-pocket limit</a>?</a>	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-866-494-2111 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None
	Preventive care/ screening/immunization	No charge <u>Deductible</u> does not apply	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> at an outpatient facility 20% <u>coinsurance</u> in the office	40% <u>coinsurance</u> at an outpatient facility 40% <u>coinsurance</u> in the office	\$750 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition  More information about prescription drug coverage	Generic drugs (Tier 1)	\$10 <u>copay</u> /prescription (retail 30 days), \$25 <u>copay</u> /prescription (retail & home delivery 90 days) <u>Deductible</u> does not apply	50% <u>coinsurance</u> /prescription (retail); Not covered (home delivery) <u>Deductible</u> does not apply	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <u>Specialty drugs</u> . Certain limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
is available at <a href="http://www.cigna.com">www.cigna.com</a>	Preferred brand drugs (Tier 2)	\$20 <a href="#">copay</a> /prescription (retail 30 days), \$50 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) <a href="#">Deductible</a> does not apply	including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	\$40 <a href="#">copay</a> /prescription (retail 30 days), \$100 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) <a href="#">Deductible</a> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 <a href="#">deductible</a> /admission, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$250 <a href="#">deductible</a> /admission, plus 40% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$150 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted. Out-of-network services are paid at the in-network cost share.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> . Services for MH/SA diagnoses will be payable according to <a href="#">Emergency room care</a> benefits.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">deductible</a> /admission, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$500 <a href="#">deductible</a> /admission, plus 40% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /office visit** 20% <a href="#">coinsurance</a> /all other services** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /office visit 40% <a href="#">coinsurance</a> /all other services	\$750 penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	\$250 <a href="#">deductible</a> /admission, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$500 <a href="#">deductible</a> /admission, plus 40% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$250 <a href="#">deductible</a> /admission, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$500 <a href="#">deductible</a> /admission, plus 40% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Coverage is limited to 100 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**  \$20 <a href="#">copay</a> /visit for Chiropractic care** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /visit for Physical, Speech, Hearing & Occupational therapy  40% <a href="#">coinsurance</a> /visit for Chiropractic care	Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 12 visits annual max for Chiropractic care services.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit for Physical, Speech, Hearing & Occupational therapy** ** <u>Deductible</u> does not apply	40% <u>coinsurance</u> /visit for Physical, Speech, Hearing & Occupational therapy	Services are covered when <u>Medically Necessary</u> to treat a mental health condition (e.g. autism) or a congenital abnormality.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	\$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	20% <u>coinsurance</u> /inpatient services 20% <u>coinsurance</u> /outpatient services	40% <u>coinsurance</u> /inpatient services 40% <u>coinsurance</u> /outpatient services	\$750 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Children)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (12 visits)

### **Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-866-494-2111, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### **Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### **Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-494-2111.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and excluded services under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles*</a>	\$750
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$2,200
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,990</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$860</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.