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. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $450/individual or $900/family For out-of-network providers: $900/individual or $1,800/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $35 for out-of-network outpatient hospital visit and $500 per admission for out-of-network hospital stay There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual or $6,000/family For out-of-network providers: Unlimited/individual or Unlimited/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$35 copay, plus 20% coinsurance/visit Deductible does not apply	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	None
	Specialist visit	$35 copay, plus 20% coinsurance/visit Deductible does not apply	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening**	Not covered/visit Not covered/screening	None None
		No charge/immunizations**	Not covered/immunizations	None
		**Deductible does not apply		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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 have a test	Diagnostic test (x-ray, blood work)	$35 copay, plus 20% coinsurance/x-ray 20% coinsurance/blood work 20% coinsurance/independent lab	$35 deductible, plus 40% coinsurance/x-ray $35 deductible, plus 40% coinsurance/blood work 40% coinsurance/independent lab	None
	Imaging (CT/PET scans, MRIs)	$35 copay, plus 20% coinsurance	$35 deductible, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition: More information about prescription drug coverage is available at www.express-scripts.com or 1-855-596-4432	Generic drugs	Retail Pharmacy for 30-day supply: $8 copayment per prescription; Mail Order for 90-day supply: $15 copayment per prescription. No charge for FDA-approved generic contraceptives.	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and can file a claim with Express Scripts for reimbursement. The Plan reimburses no more than it would have paid had you used a Network pharmacy.	• Deductible does not apply. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 30% coinsurance; Mail Order for 90-day supply: $45 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate or unavailable.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance; Mail Order for 90-day supply: $60 copayment per prescription.		
	Specialty drugs	You pay 50% coinsurance up to $60 for up to a 30-day supply.		Deductible does not apply. Specialty drugs require preauthorization (to avoid non-payment) by calling Accredo at 1-800-803-2523.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit, plus 20% coinsurance	$35 deductible/visit, plus 40% coinsurance	$750 penalty for no out-of-network precertification. Per visit copay/ deductible is waived for non-surgical procedures.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	Medical/Surgical: 20% coinsurance; after Deductible Mental Health/Substance Use Disorder Services: No charge (0% coinsurance; Deductible does not apply)	Medical/Surgical: 20% coinsurance; after Deductible Mental Health/Substance Use Disorder Services: No charge (0% coinsurance; Deductible does not apply)	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$40 copay/visit, plus 20% coinsurance Deductible does not apply	$40 copay/visit, plus 20% coinsurance Deductible does not apply	None

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 have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay, plus 20% coinsurance/office visit** 20% coinsurance/all other services **Deductible does not apply	$35 deductible, plus 40% coinsurance/office visit** 40% coinsurance/all other services **Deductible does not apply	$750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
If you are pregnant	Office visits	20% coinsurance	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification. 16 hour maximum per day

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 help recovering or have other special health needs	Rehabilitation services	20% coinsurance/visit** $35 copay, plus 20% coinsurance/PCP visit for Chiropractic care services** $35 copay, plus 20% coinsurance/ Specialist visit for Chiropractic care services** **Deductible does not apply	40% coinsurance/visit	$750 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Cardiac rehab services; 30 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance/visit Deductible does not apply	40% coinsurance/visit	$750 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary 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.
	Skilled nursing care	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Not covered/inpatient services 40% coinsurance/outpatient services	$750 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge when obtained during a preventive care office visit	Not covered	Covered for children up to 19 years. Adults pay 100% of these expenses.
	Children's glasses	Not covered	Not covered	You pay 100% of these expenses.
	Dental check-up	No charge		No charge up to $750 / family for dental care

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (in-network only Surgeon Charges Lifetime max $10,000)
- Chiropractic care (30 days)

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 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 1-800-Cigna24. 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.

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 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*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 plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$450
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$3,080

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$4,920

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$450
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$1,060

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, **800.537.7697 (TDD)**

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).