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: $500/individual or $1,500/family For out-of-network providers: $1,500/individual or $4,500/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, Diagnostic Skin Cancer Screening, Diagnostic Mammograms, office 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $4,000/individual or $8,000/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 In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply	75% coinsurance	None
	Specialist visit	$20 copay/visit Deductible does not apply	75% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** Including Diagnostic Skin Cancer Screening and Diagnostic Mammogram	Not covered/visit Not covered/screening 75% coinsurance	None None
		No charge/immunizations** **Deductible does not apply	Not covered/immunizations	None 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.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	75% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Imaging (CT/PET scans, MRIs)	No charge	75% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at MedImpact www.medimpact.com or (866) 387-3537, mandatory Specialty Drug Advocacy at PaydHealth (877) 422-1776; for Medicare eligible retiree prescription drug coverage contact VibrantRX www.MyVibrantRx.com or (844) 826-3451 (no PaydHealth required for Medicare eligible retirees). Maximum prescription drug out-of- pocket expense: $2,500 single and $5,000 family	Generic drugs, Specialty Generic and Specialty Preferred (for Medicare Part D only)	20% coinsurance (30 days: $5 min/$50 max; 90 days: $10 min/$100 max	In-Network coinsurance plus balance bill (and limited to 30-day supply only)	Some drugs require precertification's, step therapy and/or have quantity limitations. 90-day supply obtained at mail order or in network Retail Pharmacies. Specialty drugs limited to 30-day supply at MedImpact Specialty Pharmacy and may have preferred drug list with exclusions. Generic or Preferred Brand Diabetic Insulin at Generic copays to max copay $35 for 30-day supply or $105 for 90-day supply, if better. Non-Preferred Brand Diabetic Insulin at regular copays to same $35/$105 max copays, if better. Generic and Preferred Brand Diabetic supplies and equipment 100% covered. Pay penalty price if Brand drug used when Generic is available. Cost share waived for preventive generic and single source brand name contraceptive drugs/devices for women, preventive vaccinations (network participating pharmacies only). Not covered: most over-the-counter drugs, drugs to treat infertility, certain dental drugs, non-prescription contraceptives, drugs on PaydHealth list for members who are required but choose not to participate in advocacy services.
	Preferred brand drugs, Specialty Brand and Specialty Non-Preferred (for Medicare Part D only)	25% coinsurance (30 days: $30 min/$100 max; 90 days: $50 min/$200 max	In-Network coinsurance plus balance bill (and limited to 30-day supply only)	
	Non-Preferred Brand drugs and Specialty Non-preferred Brand (not applicable to Medicare Part D)	40% coinsurance (30 days: $50 min/$150 max; 90 days: $80 min/$300 max	In-Network coinsurance plus balance bill (and limited to 30-day supply only)	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	50% coinsurance	50% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	50% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit** No charge/all other services** **Deductible does not apply	75% coinsurance/office visit 75% coinsurance/all other services	$750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge Deductible does not apply	75% coinsurance	$750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge after $300 Maternity copay	75% coinsurance	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).
	Childbirth/delivery professional services	No charge after $300 Maternity copay	75% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	75% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	50% coinsurance	75% coinsurance	$750 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of 90 days for Cognitive therapy, Physical therapy, Occupational therapy and Speech therapy. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	50% coinsurance	75% coinsurance	$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). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	50% coinsurance	75% coinsurance	$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	50% coinsurance	75% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	50% coinsurance/inpatient services 50% coinsurance/outpatient services	75% coinsurance/inpatient services 75% coinsurance/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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- 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)
- Chiropractic care
- Hearing aids (in-network only/2 devices per 60 months)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	$500
Copayments	$30
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$4,050

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$660

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

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	$500
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,400

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

Plan Name: Basic Plan **Ben Ver:** 29 **Plan ID:** 17163090