



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 1-800-Cigna24 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <p><b>What is the overall <a href="#">deductible</a>?</b></p>                                | <p>For <a href="#">in-network providers</a>: \$1,500/individual - employee only or \$3,000/family maximum<br/>                     For <a href="#">out-of-network providers</a>: \$3,000/individual - employee only or \$6,000/family maximum<br/>                     Combined medical/behavioral and pharmacy <a href="#">deductible</a><br/> <a href="#">Deductible</a> per individual applies when the employee is the only individual covered under the <a href="#">plan</a>.</p> | <p>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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.</p>  |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>    | <p>Yes. In-network <a href="#">preventive care</a> &amp; immunizations.</p>  | <p>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>.</p> |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>             | <p>No.</p>   | <p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>   |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p> | <p>For <a href="#">in-network providers</a>: \$3,800/individual - employee only or \$7,600/family maximum (no more than \$6,650 per individual - within a family)<br/>                     For <a href="#">out-of-network providers</a>: \$7,300/individual - employee only or \$14,600/family maximum (no more than \$14,600 per individual - within a family)<br/>                     Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a></p>              | <p>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.</p>  |
| <p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>               | <p>Penalties for failure to obtain <a href="#">pre-authorization</a> for services, certain drug coupon amounts, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>  | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>  |

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



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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)   |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness         | 20% <a href="#">coinsurance</a> /visit  | 40% <a href="#">coinsurance</a>  | None  |
|  | <a href="#">Specialist</a> visit                         | 20% <a href="#">coinsurance</a> /visit  | 40% <a href="#">coinsurance</a>  | None  |
|  | <a href="#">Preventive care/ screening/ immunization</a> | No charge/visit**<br>No charge/ <a href="#">screening</a> **<br>No charge/immunizations**<br><br>** <a href="#">Deductible</a> does not apply | 40% <a href="#">coinsurance</a> /visit<br>40% <a href="#">coinsurance/ screening</a><br>40% <a href="#">coinsurance/ immunizations</a> | None<br>None<br>None<br><br>You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)      | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
|  | Imaging (CT/PET scans, MRIs)                             | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 50% 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                                  |   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com">www.cigna.com</a> | Generic drugs (Tier 1)                           | \$10 <a href="#">copay</a> /prescription (retail 30 days), \$10 <a href="#">copay</a> /prescription (retail & home delivery 90 days)           | 40% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a> .<br>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
|   | Preferred brand drugs (Tier 2)                   | 35% <a href="#">coinsurance</a> /prescription (retail 30 days), 35% <a href="#">coinsurance</a> /prescription (retail & home delivery 90 days) | 40% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) |   |
|   | Non-preferred brand drugs (Tier 3)               | 50% <a href="#">coinsurance</a> /prescription (retail 30 days), 50% <a href="#">coinsurance</a> /prescription (retail & home delivery 90 days) | 40% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | 50% penalty for no out-of-network precertification.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | 50% penalty for no out-of-network precertification.   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | Out-of-network services are paid at the in-network cost share and <a href="#">deductible</a> .  |
|   | <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> .  |
|   | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>   | None  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | 50% penalty for no out-of-network precertification.   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | 50% 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 20% <a href="#">coinsurance</a> /office visit<br>20% <a href="#">coinsurance</a> /all other services | 40% <a href="#">coinsurance</a> /office visit<br>40% <a href="#">coinsurance</a> /all other services | 50% penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).   |
|  | Inpatient services                        | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  | 50% penalty for no out-of-network precertification.   |
| <b>If you are pregnant</b>   | 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.<br><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .<br>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     | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>  |   |

| Common Medical Event  | Services You May Need                     | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information   |
|---|---|---|--|--|
|   |   | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                    | 50% penalty for no out-of-network precertification.<br>16 hour maximum per day   |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a> /visit          | 40% <a href="#">coinsurance</a> /visit             | 50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 40 days for <a href="#">Rehabilitation services</a> ; 36 days for Cardiac rehab services; 10 days for Chiropractic care services<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
|   | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a> /visit          | 40% <a href="#">coinsurance</a> /visit             | 50% penalty for failure to precertify out-of-network speech therapy services. Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.                            |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                    | 50% penalty for no out-of-network precertification.<br>Coverage is limited to 60 days annual max.  |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                 | 40% <a href="#">coinsurance</a>                    | 50% 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
|  | <a href="#">Hospice services</a> | 20% <a href="#">coinsurance</a> /inpatient services<br>20% <a href="#">coinsurance</a> /outpatient services | 40% <a href="#">coinsurance</a> /inpatient services<br>40% <a href="#">coinsurance</a> /outpatient services | 50% penalty for failure to precertify out-of-network inpatient <a href="#">hospice services</a> . |
| 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>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> </ul> | <ul style="list-style-type: none"> <li>• Eye care (Children)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|--|---|

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

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery (in-network only)</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care (10 days)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (\$5,000 maximum per Lifetime)</li> </ul> |
|---|---|---|

### 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 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 1-800-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](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 1-800-244-6224.

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, kwijigo 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](#) \$1,500
- [Specialist coinsurance](#) 20%
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Peg would pay is</b> | <b>\$3,730</b> |

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,810</b> |

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