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: $750/individual or $1,500/family For out-of-network providers: $1,500/individual or $3,000/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, in-network prescription drugs, emergency room visits, urgent care facility visits, and out-of-network home health care.	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: $3,000/individual or $6,000/family For out-of-network providers: $6,000/individual or $12,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	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

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail 90 days); $20 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $60 copay/prescription (retail 90 days); $60 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail 30 days), $100 copay/prescription (retail 90 days); $100 copay/prescription (home delivery 90 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information

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)	
	Rehabilitation services	$30 copay/PCP visit** $50 copay/ Specialist visit** **Deductible does not apply	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 30 days per therapy each for Pulmonary rehab, Cognitive therapy services, Physical and Occupational therapies and Speech therapy. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$30 copay/PCP visit** $50 copay/ Specialist visit** **Deductible does not apply	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	50% 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	50% penalty for no out-of-network precertification. Coverage is limited to 120 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	40% coinsurance/inpatient services 40% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental	Children's eye exam	Not covered	Not covered	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)	
or eye care	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Hearing aids (in-network only/$5,000 maximum per Calendar Year)
- Infertility treatment

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. 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-

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.

[redacted]

Cost Sharing	
Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
The plan's overall deductible	$750
Specialist copayment	$50
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	$750
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$3,000

Cost Sharing	
[redacted] ell-being and a hospital delivery)	
The plan's overall deductible	$750
Specialist copayment	$50
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	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$960

Cost Sharing	
Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$750
Specialist copayment	$50
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)*