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 $1,000/family<br>For out-of-network providers: $500/individual or $1,000/family<br>Combined medical/behavioral and pharmacy deductible | 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 and out-of-network preventive care & immunizations. | 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 |

| Important Questions | Answers | Why This Matters: |
| --- | --- | --- |
| | | |

| 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) | |
| www.cigna.com | Preferred brand drugs (Tier 2) | 20% coinsurance/prescription (retail 30 days), 20% coinsurance/prescription (retail 90 days); 20% coinsurance/prescription (home delivery 90 days) | 20% coinsurance/prescription (retail); Not covered (home delivery) | including, for example: prior authorization, step therapy, quantity limits. In-network F83 0 1 RG 0.6000000u7000 limits. 2) |
| | Non-preferred brand drugs (Tier 3) | 20% coinsurance/prescription (retail 30 days), 20% coinsurance/prescription (retail 90 days); 20% coinsurance/prescription (home delivery 90 days) | 20% coinsurance/prescription (retail); Not covered (home delivery) | |

| 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) | |
| | Habilitation services | 20% coinsurance/visit | 20% coinsurance/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.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 50% penalty for no out-of-network precertification.<br>Coverage is limited to 120 days annual max. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 50% penalty for no out-of-network precertification. |
| | Hospice services | 20% coinsurance/inpatient services<br>20% coinsurance/outpatient services | 20% coinsurance/inpatient services<br>20% coinsurance/outpatient services | 50% penalty for failure to precertify out-of-network inpatient hospice services. |
| 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:

## 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

## 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 1-800-318-2596.

## 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. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates at (888) 614-5400.

## Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insuranc 1 RG 0.600000Sppeal

## 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<br>(9 months of in-network pre-natal care and a hospital delivery) | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition) | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care) |
|---|---|---|