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.

	For in-network providers: $500/individual or $1,000/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.
	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/.
	No.	You don't have to meet deductibles for specific services.
	For in-network providers: $2,800/individual or $6,000/family For out-of-network providers: $7,500/individual or $18,750/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.
	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.

_____	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.
_____ _____	No.	You can see the specialist you choose without a referral.

All _____ and _____ costs shown in this chart are after your _____ has been met, if a _____ applies.

Generic drugs (Tier 1)

	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% penalty for no out-of-network precertification.
	Outpatient services	$25 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	30% coinsurance/office visit 30% coinsurance/all other services	50% 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	20% coinsurance	30% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
	Office visits	20% coinsurance	30% 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	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
	Home health care	20% coinsurance	30% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)

	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

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-

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 charhual costs will be different