



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 : \$1,600/individual or \$3,200/family For out-of-network providers : \$3,200/individual or \$6,400/family Amount your employer contributes to your account: Up to \$500/individual or \$1,000/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, emergency room visits, urgent care facility 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 : \$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 1-855-869-8619 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 | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$35 copay /visit Deductible does not apply | 30% coinsurance | None |
| | Specialist visit | \$50 copay /visit Deductible does not apply | 30% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge Deductible does not apply | 30% coinsurance | 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) | 10% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| If you need drugs to treat your illness or condition More information about prescription drug | Generic drugs (Tier 1) | Not covered | Not covered | Coverage provided by Express Scripts. |
| | Preferred brand drugs (Tier 2) | Not covered | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Not covered | Not covered | |

| 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) | |
| coverage is available at www.express-scripts.com | Specialty drugs (Tier 4) | Not covered | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| If you need immediate medical attention | Emergency room care | \$175 copay /visit Deductible does not apply | \$175 copay /visit Deductible does not apply | Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Out-of-network air ambulance services are paid at the in-network cost share and deductible . |
| | Urgent care | \$50 copay /visit Deductible does not apply | \$50 copay /visit Deductible does not apply | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 copay /office visit** 10% coinsurance /all other services ** Deductible does not apply | First 12 visits per Lifetime 10% coinsurance Deductible does not apply 13th visit and after \$35 copay, and plan pays 100% 30% coinsurance /all other services | \$500 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). |
| | Inpatient services | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| If you are pregnant | Office visits | 10% coinsurance | 30% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm |

| 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) | |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | 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 facility services | 10% coinsurance | 30% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. 16 hour maximum per day |
| | Rehabilitation services | \$35 copay /visit Deductible does not apply | 30% coinsurance /PCP visit 30% coinsurance / Specialist visit | \$500 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 80 days for Rehabilitation services ; 36 days for Cardiac rehab services; 20 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | \$35 copay /visit Deductible does not apply | 30% coinsurance /PCP visit 30% coinsurance / Specialist visit | \$500 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. |

| 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) | |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | \$500 penalty for no out-of-network precertification. |
| | Hospice services | 10% coinsurance /inpatient services 10% coinsurance /outpatient services | 30% coinsurance /inpatient services 30% coinsurance /outpatient services | \$500 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 .) | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Eye care (Children) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Prescription drugs | <ul style="list-style-type: none"> • 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.) | | |
| <ul style="list-style-type: none"> • Acupuncture (20 days) | <ul style="list-style-type: none"> • Chiropractic care (20 days) • Hearing aids (1 device per 36 months) | <ul style="list-style-type: none"> • Infertility treatment (\$15,000 lifetime maximum) |

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: New Hampshire Department of Insurance at (800) 852-3416.

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, kwijjigo 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](#) \$1,600
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,600 |
| Copayments | \$40 |
| Coinsurance | \$1,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$30 |
| The total Peg would pay is | \$2,770 |

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$120 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$4,820 |

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$980 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$1,390 |

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