



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:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> : \$3,200/individual or \$6,400/family For <a href="#">out-of-network providers</a> : \$4,100/individual or \$8,200/family Combined medical/behavioral and pharmacy <a href="#">deductible</a> Amount your employer contributes to your account: Up to \$500/individual or \$1,000/family	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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> & immunizations.	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> : \$4,200/individual or \$8,400/family For <a href="#">out-of-network providers</a> : \$6,500/individual or \$13,000/family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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 1-855-869-8619 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 (You will pay the least)	Out-of-Network Provider (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	10% <a href="#">coinsurance</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/ screening/ immunization</a>	No charge <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	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)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug</a>	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)	
<a href="#">coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	<a href="#">Specialty drugs</a> (Tier 4)	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <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>	10% <a href="#">coinsurance</a>	10% <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>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a> /office visit 10% <a href="#">coinsurance</a> /all other services	First 12 visits per Lifetime 10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply  13th visit and after 10% <a href="#">coinsurance</a> /office visit 30% <a href="#">coinsurance</a> /all other services	\$500 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
<b>If you are pregnant</b>	Office visits	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	

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 facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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).
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification. 16 hour maximum per day
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> /visit	30% <a href="#">coinsurance</a> /visit	\$500 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 80 days for <a href="#">Rehabilitation services</a> ; 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.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a> /visit	30% <a href="#">coinsurance</a> /visit	\$500 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.  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)	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 penalty for no out-of-network precertification.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> /inpatient services 10% <a href="#">coinsurance</a> /outpatient services	30% <a href="#">coinsurance</a> /inpatient services 30% <a href="#">coinsurance</a> /outpatient services	\$500 penalty for no out-of-network precertification.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Eye care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• <a href="#">Prescription drugs</a></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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (20 days)</li> <li>• Bariatric surgery (if you qualify for coverage)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (20 days)</li> <li>• Hearing aids (1 device per 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (\$15,000 lifetime maximum)</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). 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](#) \$3,200
- [Specialist coinsurance](#) 10%
- 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*)

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

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Peg would pay is</b>	<b>\$4,130</b>

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

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist coinsurance](#) 10%
- 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*)

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

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,140
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,440</b>

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

- The [plan's](#) overall [deductible](#) \$3,200
- [Specialist coinsurance](#) 10%
- 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*)

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

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,790
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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