

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

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 1-800-Cigna24 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

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com">www.cigna.com</a></p>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /prescription (retail 30 days), \$30 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) <a href="#">Deductible</a> does not apply	<p>Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a>. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p> <p>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.</p> <p>In-network Federally required preventive drugs will be provided at no charge.</p> <p>The lesser of 50% or \$500 penalty for no out-of-network precertification.</p>
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail 30 days), \$60 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) <a href="#">Deductible</a> does not apply	
	Non-preferred brand drugs (Tier 3)	\$50 <a href="#">copay</a> /prescription (retail 30 days), \$100 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	20% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery) <a href="#">Deductible</a> does not apply	
Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <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)	

	Outpatient services	\$25 <a href="#">copay</a> /office visit** 20% <a href="#">coinsurance</a> /all other services		
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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="#">Habilitation services</a>	\$25 <a href="#">copay</a> /PCP visit** \$25 <a href="#">copay</a> / <a href="#">Specialist</a> visit** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /PCP visit 40% <a href="#">coinsurance</a> / <a href="#">Specialist</a> visit	The lesser of 50% or \$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.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	The lesser of 50% or \$500 penalty for no out-of-network precertification. Coverage is limited to 150 days annual max.
	<a href="#">Durable medical equipment</a>	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	The lesser of 50% or \$500 penalty for no out-of-network precertification.
	<a href="#">Hospice services</a>	No charge/inpatient services** No charge/outpatient services** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /inpatient services 40% <a href="#">coinsurance</a> /outpatient services	The lesser of 50% or \$500 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	Coverage is limited to one exam
	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](#).)

Bariatric surgery	Long-term care	Routine foot care
Cosmetic surgery	Non-emergency care when traveling outside the U.S.	Weight loss programs
Dental care (Adult)	Private-duty nursing	
Dental care (Children)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

Acupuncture (20 days)	Hearing aids (2 (one per ear) devices per 36 months)	Infertility treatment
Chiropractic care (combined with <a href="#">Rehabilitation Services</a> )		Routine eye care (Adult)

### 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: Cigna at 1-800-Cigna24, Maine Bureau of Insurance at 1-800-300-5000 and 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) or Maine Bureau of Insurance at 1-800-300-5000. Additionally, a consumer assistance program can help you file your [appeal](#). Contact: Bureau of Insurance State of Maine at (800) 300-5000.

### 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 ( ): 1-800-244-6224.

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](#) \$500
- ☐ [Specialist copayment](#) \$25
- ☐ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$2,960

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

- ☐ The [plan's](#) overall [deductible](#) \$500
- ☐ [Specialist copayment](#) \$25
- ☐ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$960

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

- ☐ The [plan's](#) overall [deductible](#) \$500
- ☐ [Specialist copayment](#) \$25
- ☐ 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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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

Plan Name: Basic Ben Ver: 31 Plan ID: 35399001







the **English**. **ATTENTION:** Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers call

