

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and others would share the cost for covered health care services. NOTE: Information about the cost of (that is, 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 to <https://www.healthcare.gov/coverage>. For general definitions of common terms, such as allowed amount, balance billing, insurance payment, 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:
<p>What is the overall <u>deductible</u>?</p>	<p>For <u>in-network providers</u>: \$3,300/individual - employee or \$6,600/family maximum (no more than \$3,300 per individual within a family)                      For <u>out-of-network providers</u>: \$3,300/individual - employee or \$6,600/family maximum (no more than \$3,300 per individual within a family)                      Combined medical/behavioral and pharmaceutical <u>deductible</u></p>	<p>Generally, you must pay all of the costs <u>up to the deductible</u> amount before <u>the plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. In-network <u>preventive care</u> &amp; immunizations, in-network preventive drugs.</p>	<p>This <u>plan</u> covers some items and services even if you have not met the <u>deductible</u> amount. <u>Cost-sharing</u> or <u>insurance</u> may apply. For example, <u>this</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See the list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the</p>		

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 <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 the <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 that a <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 with a <a href="#">referral</a> .

All [copayment](#) and [coinsurance](#) costs shown in this chart are after the [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 injury or illness	10% <a href="#">coinsurance</a> /office visit	30% <a href="#">coinsurance</a>	No Charge after plan deductible is met. Initial visit per Calendar Year.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> /MDLIVE visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	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.
	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <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)	
	Preferred brand drugs (1 2)			

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)	
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<p>The lesser of 50% or \$500 penalty with no out-of-network precertification. Includes medical services for MRSA diagnoses.</p> <p>Primary Care <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.</p> <p><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>.</p> <p>Depending on the type of service, <a href="#">copayment</a>, <a href="#">coinsurance</a>, or <a href="#">deductible</a> may apply. Maternity care may include tests, ultrasounds, and hospital stays.</p>
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility 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)	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	The lesser of 50% or \$500 penalty no out-of-network precertification
	<a href="#">Hospice services</a>	No charge/inpatient services No charge/outpatient services	30% <a href="#">coinsurance</a> /inpatient services 30% <a href="#">coinsurance</a> /outpatient services	The lesser of 50% or \$500 penalty no out-of-network precertification
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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 document for more information and a list of any <a href="#">excluded services</a> .)			
Bariatric surgery	Cosmetic surgery	Dental care (Adult)	Dental care (Children)
Long-term care	Non-emergency care when traveling outside U.S.	Private-duty nursing	Routine foot care
Weight loss programs			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please <a href="#">refer to your policy document</a> .)			
Acupuncture (20 days)	Chiropractic care (combined with <a href="#">Rehabilitation Services</a> )	Hearing aids (2 (one per ear) devices per 36 months)	Infertility treatment
			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 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.dhs.gov/ebsa](http://www.dhs.gov/ebsa) or [www.dhs.gov/ebsa](http://www.dhs.gov/ebsa) (www)1(.haebsa/hea to cthre)-1(TJ ET q 0 0 1(ervice it TJ 1 0 Q q ds.op these serbTJ ET availqupnmur y0 0 -u,mur

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint [against a denial of a claim](#). This complaint is called a [grievance appeal](#). For more informati

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how costs might cover medical care. Your actual costs will be depending on the actual care you receive, the prices providers charge, and many other factors. Focus on sharing amounts (deductibles, payments and insurance) and excluded services under the plan. Use this information to compare the portion of costs 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 hospital delivery)

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

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

The plan's overall deductible	\$3,300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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This EXAMPLE event includes services like  
[Specialist office visit \(pre-natal care\)](#)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests \(ultrasounds and blood work\)](#)  
[Specialist visit \(anesthesia\)](#)

This EXAMPLE event includes services like  
[Primary care physician office visit \(including disease education\)](#)







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

