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, call 800-842-5899. 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:/healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $5,500/individual; $11,000/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. Generic (Tier 1) prescription drugs, primary care In-Network provider office visits and preventive services.	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?	In-Network: $7,150/individual; $14,300/family	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?	Premiums; balance-billing charges; and healthcare this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.myCigna.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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral, except that the plan will not cover tests or examinations performed by an Audiologist unless ordered by your doctor.

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)	Non-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	$40 copay/visit Deductible does not apply	Not Covered	None
	Specialist visit	40% coinsurance	Not Covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. No charge for Cologuard® for colorectal cancer screening up to $700; amounts over $700 subject to deductible and 20% coinsurance if you participate in the plan's wellness program or 30% coinsurance if no wellness participation.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not Covered	Preauthorization is required for genetic testing. No coverage if you fail to obtain preauthorization.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	Preauthorization is required. No coverage if you fail to obtain preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com	Generic drugs	$20 copay/prescription (retail 30 days), $40 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery) for Tier 1, Tier 2 and Tier 3 drugs. Coverage is limited up to a 30-day supply for Tier 4 drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs	$50 copay/prescription (retail 30 days), $100 copay/prescription (retail & home delivery 90 days)	Not covered	
	Non-preferred brand drugs	You pay 60% with a minimum of $100 copay/prescription (retail 30 days), You pay 60% with a minimum of $200 copay/prescription (retail & home delivery 90 days)	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)	Non-Network Provider (You will pay the most)	
	Specialty drugs	You pay 60% coinsurance with a minimum of $100 copay/ prescription (retail & home delivery 30 days)	Not covered	Specialty drugs (Tier 4) applies only to self-administered injectable prescriptions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	Preauthorization is required. No coverage if you fail to obtain preauthorization.
	Physician/surgeon fees	40% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	40% coinsurance	Not Covered	None.
	Emergency medical transportation	40% coinsurance	Not Covered	None.
	Urgent care	40% coinsurance	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	Admissions must be preauthorized or certified. No coverage for stays/days if you fail to obtain preauthorization or certification.
	Physician/surgeon fees	40% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit** **Deductible does not apply 40% coinsurance/other outpatient services	Not covered	Precertification is required for certain outpatient services
	Inpatient services	40% coinsurance	Not covered	Admissions must be preauthorized or certified. No coverage for stays/days if you fail to obtain preauthorization or certification.
If you are pregnant	Office visits	40% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent child pregnancy charges excluded, except for mandated preventive services.
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or	Home health care	40% coinsurance	Not covered	16 hour maximum per day Precertification is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
have other special health needs	Rehabilitation services	$40 copay/PCP visit** **Deductible does not apply 40% coinsurance/Specialist visit	Not covered	Coverage for Rehabilitation, including Cardiac rehab and Chiropractic care, services is limited to 60 days annual max. Precertification is required for Speech therapy. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	40% coinsurance	Not covered	Coverage is limited to 60 days annual max. Precertification is required for admission to skilled nursing facility
	Durable medical equipment	40% coinsurance	Not covered	Precertification is required
	Hospice services	40% coinsurance	Not covered	Precertification is required for admission to hospice facility
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.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Dental care (Adult)
- Dental care (Children)
- Eye care (children)
- Hearing aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy related charges for dependent children, except those covered under preventive care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Substance abuse services
- Weight loss programs

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

- Chiropractic care (limited to 60 days annual maximum, combined with other Rehabilitation services)

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, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Florida Office of Insurance Regulation at 1-877-693-5236 or www.floir.com or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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, kwiijigo 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	$1,150
Specialist coinsurance	40%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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:	
Cost Sharing	
Deductibles	$5,500
Copayments	$10
Coinsurance	$1,410
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$6,940**

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

The plan's overall deductible	$1,150
Specialist coinsurance	40%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:	
Cost Sharing	
Deductibles	$4,200
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,620**

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

The plan's overall deductible	$1,150
Specialist coinsurance	40%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:	
Cost Sharing	
Deductibles	$2,790
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.