




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:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network</a> : \$5,500/individual; \$11,000/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. Generic (Tier 1) <a href="#">prescription drugs</a> , primary care <a href="#">In-Network provider</a> primary care office visits and <a href="#">preventive services</a> .	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>	<a href="#">In-Network</a> : \$7,150/individual; \$14,300/family	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>	<a href="#">Premiums</a> ; <a href="#">balance-billing</a> charges; and healthcare 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.myCigna.com">www.myCigna.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 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> , except that the <a href="#">plan</a> 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need 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)	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	<a href="#">Preauthorization</a> is required for genetic testing. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a>	Generic drugs	\$20 <a href="#">copay</a> /prescription (retail 30 days), \$40 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> 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.
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription (retail 30 days), \$100 <a href="#">copay</a> /prescription (retail & home delivery 90 days)	Not covered	
	Non-preferred brand drugs	You pay 60% with a minimum of \$100 <a href="#">copay</a> /prescription (retail 30 days), You pay 60% with a minimum of \$200 <a href="#">copay</a> /prescription (retail & home delivery 90 days)	Not covered	Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	<a href="#">Specialty drugs</a>	You pay 60% <a href="#">coinsurance</a> with a minimum of \$100 <a href="#">copay</a> /prescription (retail & home delivery 30 days)	Not covered	<a href="#">Specialty drugs</a> (Tier 4) applies only to self-administered injectable prescriptions.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	Covered as <a href="#">In-Network Provider</a>	None.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	Covered as <a href="#">In-Network Provider</a>	None.
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not Covered	Admissions must be <a href="#">preauthorized or certified</a> . No coverage for stays/days if you fail to obtain <a href="#">preauthorization or certification</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> /office visit** ** <a href="#">Deductible</a> does not apply 40% <a href="#">coinsurance</a> /other outpatient services	Not covered	<a href="#">Precertification</a> is required for certain outpatient services
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	Admissions must be <a href="#">preauthorized or certified</a> . No coverage for stays/days if you fail to obtain <a href="#">preauthorization or certification</a> .
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> 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 <a href="#">preventive services</a> .
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered except as required under the No Surprises Act	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	16 hour maximum per day <a href="#">Precertification</a> 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	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /PCP visit** ** <a href="#">Deductible</a> does not apply  40% <a href="#">coinsurance</a> /Specialist visit	Not covered	Coverage for Rehabilitation, including Cardiac rehab and Chiropractic care, services is limited to 60 days annual max. <a href="#">Precertification</a> is required for Speech therapy. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	Coverage is limited to 60 days annual max. <a href="#">Precertification</a> is required for admission to skilled nursing facility
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Precertification</a> is required
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Precertification</a> 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 <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>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic Surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Eye care (children)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Pregnancy related charges for dependent children, except those covered under preventive care</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>• Substance abuse services</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 [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](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, 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](http://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](http://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, kwijigo 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*)

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

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,410
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$6,940</b>

### 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*)

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

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,200
<a href="#">Copayments</a>	\$420
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$4,620</b>

### 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*)

<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>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<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.