



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.myCigna.com](http://www.myCigna.com) or by calling 1-800-Cigna24.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	For in-network providers <b>\$400</b> person/ <b>\$800</b> family For out-of-network providers <b>\$800</b> person/ <b>\$1,600</b> family Does not apply to in-network preventive care, in-network office visits	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. For In-Network <b>\$2,200</b> person / <b>\$4,400</b> family For Out-of-Network <b>\$4,400</b> person / <b>\$8,800</b> family	The <b>out-of-pocket</b> limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you to plan for your health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-244-6224 for a list of network providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .
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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 co-pay /visit	30% co-insurance	-----none-----
	Specialist visit	\$40 co-pay / visit	30% co-insurance	-----none-----
	Other practitioner office visit	\$40 co-pay/visit for Chiropractor	30% co-insurance	Chiropractic – \$1,000 annual max
	Preventive care/screening/immunization	No Charge	Not Covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	30% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% co-insurance	30% co-insurance	-----none-----
If you need drugs to treat your illness or condition	Generic drugs	20% co-insurance	Not Covered	Covers up to a 30 day supply (retail prescription); Covers up to a 90 day supply (mail
	Preferred brand drugs	20% co-insurance	Not Covered	
	Non-preferred brand drugs	20% co-insurance	Not Covered	

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Specialty drugs	20% co-insurance	Not Covered	order prescription) Retail minimum \$12 Retail maximum \$120 Mail order minimum \$24 Mail order maximum \$240
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	-----none-----
	Physician/surgeon fees	10% co-insurance	30% co-insurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$100 co-pay/visit	\$100 co-pay	Per visit co-pay waived if admitted
	Emergency medical transportation	10% co-insurance	10% co-insurance	-----none-----
	Urgent care	\$50 co-pay	\$50 co-pay	Per visit co-pay waived if admitted
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% co-insurance	30% co-insurance	-----none-----
	Physician/surgeon fee	10% co-insurance	30% co-insurance	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$40 co-pay/office visit and 10% co-insurance/other outpatient services	30% co-insurance	-----none-----
	Mental/Behavioral health inpatient services	10% co-insurance	30% co-insurance	-----none-----
	Substance use disorder outpatient services	\$40 co-pay/office visit and 10% co-insurance/other outpatient services	30% co-insurance	-----none-----
	Substance use disorder inpatient services	10% co-insurance	30% co-insurance	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	\$40 co-pay for initial visit, then 10% co-insurance	30% co-insurance	-----none-----

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
	Delivery and all inpatient services	10% co-insurance	30% co-insurance	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	10% co-insurance	30% co-insurance	Coverage is limited to 100 days annual max. Maximums cross-accumulate.
	Rehabilitation services	\$40 co-pay/visit	30% co-insurance	Coverage for Rehabilitation services is limited to 25 days annual max. Cardiac Rehabilitation services are limited to 36 days annual max.
	Habilitation services	No Coverage	No Coverage	-----none-----
	Skilled nursing care	10% co-insurance	30% co-insurance	Up to 100 days per calendar year
	Durable medical equipment	10% co-insurance	30% co-insurance	-----none-----
	Hospice service	No charge	No charge	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	-----none-----
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services](#).)

- |                       |                          |  |
|-----------------------|--------------------------|--|
| • Acupuncture         | • Dental Care (Children) | • Non-emergency care when traveling outside the U.S. |
| • Bariatric Surgery   | • Eye care (Children)    | • Routine eye care (Adult)                           |
| • Cosmetic Surgery    | • Habilitation services  | • Routine foot care                                  |
| • Dental Care (Adult) | • Long-term care         | • Weight loss programs                               |

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |                     |                         |
|---------------------|-------------------------|
| • Chiropractic care | • Infertility treatment |
| • Hearing aids      | • Private duty nursing  |

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).”

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer Service at 1-800-Cigna24 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$6,260**
- **Patient pays \$1,280**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$400
Co-pays	\$40
Co-insurance	\$690
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,280</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,890**
- **Patient pays \$1,510**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$400
Co-pays	\$360
Co-insurance	\$670
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,510</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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