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. 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://www.healthcare.gov/sbc-glossary or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $4,250/individual or $8,500/family For out-of-network providers: $7,500/individual or $15,000/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. In-network Office visits, Preventive care, Independent lab, Prescription drugs, Urgent care, Outpatient mental health/substance abuse disorders office visits, Rehab/Hab, Child eye exam, Child glasses and Child dental check-up.	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?	For in-network providers: $12,000/individual or $24,000/family For out-of-network providers: $20,000/individual or $40,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	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?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care 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.cigna.com or call 1-866-494-2111 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	Out-of-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	$55 copay/visit Deductible does not apply	50% coinsurance	Cost share applies to both in-person and virtual visits.
	Specialist visit	$85 copay/visit Deductible does not apply	50% coinsurance	Cost share applies to both in-person and virtual visits.
	Preventive care/ screening/immunization	No charge Deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance/x-ray No charge/independent lab 30% coinsurance/all other outpatient lab	50% coinsurance	Out-of-network preauthorization is required for certain services. $750 penalty for failure to preauthorize.
	Imaging (CT/PET scans, MRIs)	30% coinsurance at an outpatient facility 30% coinsurance in the office	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$25 copay/prescription (retail 30 days), $75 copay/prescription (retail & home delivery 90 days); Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$40 copay/ prescription (retail 30 days); $120 copay/ prescription (retail & home delivery 90 days); Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
	Non-Preferred brand drugs (Tier 3)	$60 copay/prescription (retail 30 days); $180 copay/prescription (retail & home delivery 90 days); Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
If you need immediate medical attention	Emergency room care	$800 copay/visit	$800 copay/visit	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible. Preauthorization is required for non-emergency transportation. Services for mental health/substance abuse diagnoses will be payable by you at $0 copayment subject to deductible.

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)	
	Urgent care	$90 copay/visit Deductible does not apply	50% coinsurance	Virtual Urgent Care visits from MDLIVE Virtual Providers are covered in full; Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$55 copay/office visit Deductible does not apply 30% coinsurance/all other services	50% coinsurance	Includes medical services for mental health/substance abuse diagnoses. Out-of-network Preauthorization may be required for Other Outpatient Services. $750 penalty for failure to preauthorize. Preauthorization is not required for Outpatient Office visits.
	Inpatient services	30% coinsurance	50% coinsurance	Includes medical services for mental heath/substance abuse diagnoses. Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.

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 are pregnant	Office visits	30% coinsurance	50% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Out-of-network Preauthorization is required for a hospital stay that will exceed 48 hours following a vaginal birth or 96 hours following a cesarean section. $750 penalty for failure to preauthorize.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Coverage is limited to 42 visits annual max. Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
	Rehabilitation services	$85 copay/visit for Deductible does not apply for Physical, Speech & Occupational therapy $35 copay/visit for Deductible does not apply for Chiropractic care	50% coinsurance	Out-of-network preauthorization is required for speech therapy. $750 penalty for failure to preauthorize speech therapy. Coverage is limited to an annual max of 60 visits for Physical therapy, Speech & Occupational therapy. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

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)	
	Habilitation services	$85 copay/visit for Deductible does not apply	50% coinsurance	Out-of-network preauthorization is required for speech therapy. $750 penalty for failure to preauthorize speech therapy. Coverage is limited to an annual max of 60 visits for Physical therapy, Speech & Occupational therapy. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize. Coverage is limited to an annual max of 100 days.
	Durable medical equipment	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
	Hospice services	30% coinsurance	50% coinsurance	Out-of-network preauthorization is required. $750 penalty for failure to preauthorize.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	30% coinsurance	One (1) exam per Plan Year for children up to age 19
	Children's glasses	No charge Deductible does not apply	30% coinsurance	Limited to one pair per Plan Year from pediatric frame collection for children up to age 19. Pediatric Frames, Single Vision, Lined Bifocal, Lined Trifocal or Standard Progressive and Lenticular Lenses.
	Children's dental check-up	No charge Deductible does not apply	50% coinsurance	One (1) dental exam every 6 months for children up to age 19.

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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing

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 1-866-494-2111, Arizona Department of Insurance and Financial Institutions at 1-602-364-3100 and 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, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.govebsahealthreform or Arizona Department of Insurance and Financial Institutions at 1-602-364-3100.

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 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

*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	$4,250
Specialist copayment	$85
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$4,250
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$6,380

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

The plan's overall deductible	$4,250
Specialist copayment	$85
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	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$1,540

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

The plan's overall deductible	$4,250
Specialist copayment	$85
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	$1,930
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,330

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

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

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Proficiency of Language Assistance Services

English - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, !lame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - i±: ft{rraJf,Sf:9e.JftJHJ:t!t ia.l=l}Jij f£ ◦ It Cigna Healthcare EfJJJi P , rlfi&fflf Efl ID -t1r®Ef1 ◦ {-g 1.800.244.6224 C lr!H!H,i : ffti 711) ◦

Vietnamese - XIN LU'U Y: Quy vi dU'Q'C c p djch v1,1 trQ' giup v ng6n ngQ> mien phi. Danh cha khach hang hi(m tc;1i cua Cigna Healthcare, vui long goi s6 mc;it sau the Hoi vien. Cac tmcmg hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

Korean - -?l: J Oj J..§-o J..l:= . <2! Oj 7'1 J..i 1 A 1f-E£ Ol-§-o "? LIq_ XH Cigna Healthcare 7'fl 7' a 7JllJ..i := ID 7' 121011 := 2te:!.2.£ '2:!oH-?J..12.. 7IE q 011:= 1.800.244.6224 (TTY: qo1 711)te:! £ 2 0H-?J..l2..

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. 0 kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian - BHv1MAHv1E: BaM MoryT npeAOCTaBt,1Tb 6ecnnaTHble ycnyrn nepeBOAa. Ecm1 Bbl y)f{e y4acTByeTe B nnaHe Cigna Healthcare, no3BOHll1Te no HOMepy, yKa3aHHOMY Ha o6paTHO CTOpOHe Bawe 111A8HTll1q:>111Kal...\1110HHO KapTO4Kll1 y4aCTHll1Ka nnaHa. Ecn111 Bbl He f!BmleTeCb y4aCTHIIIKOM OAHOro 1113 HaWIIIX nnaHOB, no3BOHll1Te no HOMepy 1.800.244.6224 (TTY: 711).

Arabic .(711 '-,-l :TTY) 1.800.244.6224 '-:-l .Jl

French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS : composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servi<;:os de assistencia lingufstica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identifica<;:ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost pnej, bezpfatnej pomocy j zykowej, obecni klienci firmy Cigna Healthcare mog9 dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 51$:I:.W : 87$:iR7;£-it n -g-, *{O) iRsz::titt-I::'A7;£-c'f1JffII,'tctdt*9 IJH'IO)Cigna HealthcareO)S J;;t:_ ID:b- t- :' jijO) it:ffl: *c\ s it,LZc'Ji(tc.l,' f-O){{Q0)7J i, 1.800.244.6224 (TTY: 711) *c\ s it,LZc'Ji(tc.l,'

Italian - ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare ii numero sul retro della tessera di identificazione. In caso contrario, chiamare ii numero 1.800.244.6224 (utenti TTY: chiamare ii numero 711).

German - ACHTUNG: Die Leistungen der Sprachunterstotzung stehen Ihnen kostenlos zur Verfugung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

Persian (Farsi) .(.I:¢ c.S..>P-• .Jw 1.J 711 •.Jw :u\.ol w •y,_, •.JW) c..J"w 1.800.244.6224 •.Jw 4 W.J1 Y.F .J.I -