



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 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers : \$0/individual or \$0/family For out-of-network providers : \$5,000/individual or \$10,000/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 care | You will have to meet the deductible before the plan pays for any services. |
| Are there other deductibles for specific services? | Yes. Ambulance, Durable Medical Equipment and External Prosthetic Appliances. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For in-network providers : \$6,000/individual or \$12,000/family For out-of-network providers : \$10,000/individual or \$20,000/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 1-800-Cigna24 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. |

| 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 | \$50 copay /visit | 40% coinsurance | None |
| | Specialist visit | \$150 copay /visit | 40% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge | 40% 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) | Lab - No charge X-ray - \$90 copay | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$600 copay per type of scan/day | 40% coinsurance | 50% penalty for no precertification. |
| If you need drugs to treat your illness or condition Prescription drug coverage is provided by Express Scripts | Generic drugs (Tier 1) | Retail - \$20 copay Home Delivery - \$50 copay | Contracted Rate | Up to 34 day supply (retail) Anything over 34 day supply (home delivery). |
| | Preferred brand drugs (Tier 2) | Retail - \$120 copay Home Delivery - \$300 copay | Contracted Rate | |
| | Non-preferred brand drugs (Tier 3) | Retail - \$250 copay Home Delivery - \$625 copay | Contracted Rate | |
| | Specialty drugs (Tier 4) | Retail - \$250 copay Home Delivery - \$625 copay | Contracted Rate | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$850 copay /visit | 40% coinsurance | Per visit copay is waived for non-surgical procedures. |
| | Physician/surgeon fees | No charge | 40% coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$1,000 copay /visit | \$1,000 copay /visit | Per visit copay is waived if admitted |
| | Emergency medical transportation | \$700 benefit deductible per day | \$700 benefit deductible per day | None |

| 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 | \$75 copay /visit | 40% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,500 copay /day | 40% coinsurance | None |
| | Physician/surgeon fees | No charge | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$50 copay /office visit \$50 copay /all other services | 40% coinsurance /office visit 40% coinsurance /all other services | Includes medical services for MH/SA diagnoses. |
| | Inpatient services | \$1,500 copay /day | 40% coinsurance | Includes medical services for MH/SA diagnoses. |
| If you are pregnant | Office visits | \$50 copay for initial visit to confirm pregnancy No charge after initial visit | 40% coinsurance | 50% penalty for no precertification. Primary Care benefit levels apply for initial visit to confirm pregnancy. |
| | Childbirth/delivery professional services | No charge | 40% coinsurance | 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). |
| | Childbirth/delivery facility services | \$1,500 copay /day | 40% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | \$40 copay per day | 40% coinsurance | 50% penalty for no out-of-network precertification. Per provider type/day copay (Nurse + Physical Therapist + Wound Care CNA = 3 copays) |

| 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) | |
| <u>Rehabilitation services</u> | <u>Rehabilitation services</u> | \$60 copay | 40% coinsurance | 50% penalty for failure to precertify speech therapy services. Coverage for Rehabilitation, including Cardiac rehab and Chiropractic care services, is limited to 60 days annual max combined. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies |
| | <u>Habilitation services</u> | \$60 copay | 40% coinsurance | 50% penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies |
| | <u>Skilled nursing care</u> | \$1,500 copay per day | 40% coinsurance | 50% penalty for no precertification. |
| | <u>Durable medical equipment</u> | \$150 annual benefit deductible | 40% coinsurance | 50% penalty for no precertification. |
| | <u>Hospice services</u> | No charge/inpatient; No charge/outpatient services | 40% coinsurance /inpatient; 40% coinsurance /outpatient services | 50% penalty for failure to precertify inpatient hospice services . |
| | Children's eye exam | Not covered | Not covered | None |
| If your child needs dental or eye care | 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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (in-network only Surgeon Charges Lifetime max \$10,000)
- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (Age 18 & Under 2 devices every 2 years; 18 & Over \$3k maximum per device for 2 devices every 2 years)

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 1-800-Cigna24, 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 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact: Tennessee Department of Commerce & Insurance at (615) 741-2218.

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](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$0 |
| Copayments | \$3,200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$3,220 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$1,400 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$40 |
| The total Joe would pay is | \$1,440 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$150
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$0 |
| Copayments | \$2,200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$00 |
| The total Mia would pay is | \$2,220 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.