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 {{Customer Service Phone Number}}. 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 www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	This plan does not have a deductible.
Are there other deductibles for specific services?	**No.**	This plan does not have any deductible.
What is the out-of-pocket limit for this plan?	**$7,900/Individual; $15,800/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 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. Contact {{Customer Service Phone Number}} for assistance locating 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?	N/A	Specialists are not covered under this plan.

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
		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	$20 copay/visit.	Not covered.	Limited to three (3) visits per calendar year. Telemedicine is available for medical or mental health through MD Live and is not subject to the visit limits.
	Specialist visit	Not covered.	Not covered.	None.
	Preventive care/screening/ immunization	No cost to Covered Person.	Not covered.	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)	Not covered.	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	Not covered.	Not covered.	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MyCigna.com.	Tier 1 drugs	**Retail (30 Day Supply):** 10% Coinsurance **Retail/Mail Order (90 Day Supply):** 10% Coinsurance	Not covered.	Preventive medications are covered at no cost to the Covered Person as required by applicable law.
	Tier 2 drugs	Not covered.	Not covered.	None.
	Tier 3 drugs	Not covered.	Not covered.	None.
	Tier 4 drugs - Specialty drugs	Not covered.	Not covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	Not covered.	None.
	Physician/surgeon fees	Not covered.	Not covered.	None.
If you need immediate	Emergency room care	Not covered.	Not covered.	None.

* For more information about limitations and exceptions, and how to obtain a copy of the plan or policy document contact {{Customer Service Phone Number}}.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	Emergency medical transportation	Not covered.	Not covered.	None.
	Urgent care	$50 Copay/visit.	Not covered.	Limited to three (3) visits per calendar year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	None.
	Physician/surgeon fees	Not covered.	Not covered.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered.	Not covered.	None.
	Inpatient services	Not covered.	Not covered.	None.
If you are pregnant	Office visits	**Preventive Care:** No cost to Covered Person. **All Other Services:** Not covered.	Not covered.	Only services considered preventive care will be covered. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	Not covered.	Not covered.	None.
	Childbirth/delivery facility services	Not covered.	Not covered.	None.
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	None.
	Rehabilitation services	Not covered.	Not covered.	None.
	Habilitation services	Not covered.	Not covered.	None.
	Skilled nursing care	Not covered.	Not covered.	None.
	Durable medical equipment	Not covered.	Not covered.	None.
	Hospice services	Not covered.	Not covered.	None.
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:

* For more information about limitations and exceptions, and how to obtain a copy of the plan or policy document contact {{Customer Service Phone Number}}.

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 • Chiropractic care • Cosmetic surgery • Dental care (adult)	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside 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.)
• N/A

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, 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: {{Customer Service Phone Number}} or the Department of Labor, Employee Benefits Security Administration at (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? **No**
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 (800) 318-2596.

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

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* For more information about limitations and exceptions, and how to obtain a copy of the plan or policy document contact {{Customer Service Phone Number}}.

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	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,650
The total Peg would pay is	**$12,650**

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	**N/A**
Hospital (facility)	**N/A**
Other	**$20**

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	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,320**

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

The plan's overall deductible	**$0**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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