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, contact Cigna at 1-877-501-7992. For 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.cigna.com/fcps or call 1-877-501-7992 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.cigna.com/fcps

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $300 Individual / $600 Family Out-of-Network: $300 Individual / $600 Family In and out of network deductibles cross accumulate.	Generally, you must pay all 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. Preventive care services, telemedicine services provided through MDLive, and urgent care services are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ for a list of covered preventive services..
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 and out of network providers $2,500 individual/ $5,000 family. In and out of network out of pocket limits cross accumulate. Separate Pharmacy out of pocket maximum: Individual $1,500 / Family $3,000	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. For Pharmacy plan details, see http://info.caremark.com/fcps.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services. Copays and coinsurance for covered prescriptions apply to pharmacy out-of-pocket maximum.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Separate out-of-pocket maximums apply to medical and pharmacy benefits.
Will you pay less if you use a network provider?	Yes. See www.cigna.com/fcps or call 1-877-501-7992 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.
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
		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 per visit	10% of Allowed Amount	None.
	Specialist visit	$40 copay per visit	10% of Allowed Amount	
	Preventive care/screening/ immunization	No charge, not subject to deductible.	No charge, up to Allowed Amount	Age & frequency limits may apply. 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)	No Charge	No charge, up to Allowed Amount	
	Imaging (CT/PET scans, MRIs)	$75 copay per type of scan/day	$75 copay per type of scan/day	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://info.caremark.com/fcps .	Generic drugs	Retail: $7 / $14 / $21 (30 / 60 / 90-day supply) Mail Order: $14 (up to 90-day supply)	Pay in full, then file claim for reimbursement. Reimbursement limited to amount plan would have paid if network pharmacy was used.	Maximum $50 copay per 30-day supply of insulin. Participants using a CVS retail pharmacy for maintenance medications may receive a 90-day supply for two retail copays. Your plan uses a network of participating pharmacies and a formulary (a list of preferred covered medications). Some drugs may require preauthorization; if preauthorization is not obtained, the drug may not be covered. Deductible does not apply to prescription coverage. Certain preventive medications covered for $0 copay.
	Preferred brand drugs	20% subject to following maximums: Retail: $75 / $150 / $225 (30 / 60 / 90-day supply) Mail Order: $150 (up to 90-day supply)		
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% of cost of drug, $75 maximum, up to a 30-day supply	Must use CVS Specialty Pharmacy after first fill.	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of Allowed Amount	10% of Allowed Amount	Prior authorization may be required depending on type of service rendered.
	Physician / surgeon fees	10% of Allowed Amount	10% of Allowed Amount	
If you need immediate medical attention	Emergency room care	$250 copay then 10% of Allowed Amount	$250 copay then 10% of Allowed Amount	
	Emergency medical transportation	10% of Allowed Amount	10% of Allowed Amount	Must be medically necessary. Prior authorization required for non-emergency services..
	Urgent care	10% of Allowed Amount, not subject to deductible.	10% of Allowed Amount, not subject to deductible.	If using a non-participating provider, may be.required to pay in full & file for reimbursement.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 admission copay, plus10% of Allowed Amount	$150 admission copay, plus 10% of Allowed Amount	Prior authorization is required for all inpatient admissions.
	Physician/surgeon fees	10% of Allowed Amount	10% of Allowed Amount	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit	10% of Allowed Amount	
	Inpatient services	$150 admission copay, plus 10% of Allowed Amount	$150 admission copay, plus 10% of Allowed Amount	Prior authorization is required for all inpatient hospital and treatment facility stays. Additional professional charges may apply
If you are pregnant	Office visits	No Charge	No charge, up to Allowed Amount	Office visits and childbirth/delivery professional services include routine pre-natal, post natal and labor/delivery services provided by OB/GYN. Anesthesia services are billed separately. Cost sharing does not apply for preventive services. Prior authorization required for maternity & newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section.
	Childbirth/delivery professional services	OB/GYN services: No Charge Anesthesia services: 10% of Allowed Amount	No charge, up to Allowed Amount	
	Childbirth/delivery facility services	$150 admission copay, plus 10% of Allowed Amount	$150 admission copay, plus 10% of Allowed Amount	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

If you need help recovering or have other special health needs	Home health care	10% of Allowed Amount	10% of Allowed Amount	90 visits/calendar year; prior authorization is required
	Rehabilitation services	Inpatient: 10% of Allowed Amount Outpatient: $40 copay per visit/therapy	10% of Allowed Amount	Rehabilitation services include physical therapy (PT), speech therapy (ST), occupational therapy (OT) and psychiatric rehabilitation Inpatient and outpatient PT/ST/OT: 90 days per therapy per benefit period. Limits are combined in-network and out-of-network, and inpatient/outpatient. Utilization Management approval required after 20 visits for outpatient PT/OT/ST. .
	Habilitation services	Office visit: $40 copay per visit/therapy Outpatient Facility: 10% of Allowed Amount	10% of Allowed Amount	Prior authorization is required. Includes coverage for Autism Spectrum Disorder. Other habilitative services covered as part of Early Intervention Program (birth to age 3).
	Skilled nursing care	10% of Allowed Amount	10% of Allowed Amount	Prior authorization is required. 120-day maximum per benefit period.
	Durable medical equipment	10% of Allowed Amount	10% of Allowed Amount	Prior authorization is required for certain durable medical equipment.
	Hospice services	10% of Allowed Amount	10% of Allowed Amount	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	$20 copay	Reimbursement up to $40	Once every 12 months. Routine vision services not subject to deductible.
	Children's glasses	Standard lenses covered in full. Frames covered up to $130.	Reimbursement $40 - $80	Lenses once per 12 months; frames once per 24 months; max $130 allowance
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

- Cosmetic surgery
- Dental care (Adult and child)
- Long-term care
- 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 - subject to Utilization Management approval
- Chiropractic care – subject to Utilization Management review after 20 visits
- Infertility treatment – subject to Utilization Mgmt approval
- Hearing aids – maximum benefit of $3,000 every 36 months (combined in- and out of network)
- Non-emergency care when travelling outside the US.
- Private-duty nursing – outpatient only – limited to 120 days per benefit period
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, www.cciio.cms.gov, or call 1-877-267-2323 x61565.

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 1-877-501-7992

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa.1-877-501-7992

Chinese (中文): 如果 需要中文的帮助，请拨打这个号码.1-877-501-7992

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-501-7992.]

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	**$300**
Specialist	**$ 40**
Hospital (facility) copay	**$150**
Other	**10%**

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	$300
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

The plan's overall deductible	**$300**
Specialist	**$ 40**
Hospital (facility) copay	**$150**
Other	**10%**

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	$300
Copayments	$1,000
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,380**

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

The plan's overall deductible	**$300**
Specialist	**$ 40**
Hospital (facility) copay,	**$150**
Other	**10%**

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	$300
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

- 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 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

Nondiscrimination Complaint Coordinator
PO 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 http://www.hhs.gov/ocr/office/file/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 customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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