



Subject to plan allowable. 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.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 individual / \$0 family	Generally, you must pay all the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services, but see chart starting on page 2 for other costs for services this plan covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000 individual / \$10,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balanced-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes.	See <a href="http://www.mycigna.com">www.mycigna.com</a> for list of participating providers
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not covered if provided at a hospital. Limited to 12 visits per plan year.
	<a href="#">Specialist</a> visit	\$25 copay/visit	Not covered if provided at a hospital. Limited to 12 visits per plan year.
	<a href="#">Preventive care/screening/immunization</a>	0% coinsurance	Not covered if provided at a hospital. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Limited to 1 visit per year. Subject to plan allowable.
If you have a test	<a href="#">Diagnostic test</a> (X-Ray & Lab)	Independent Lab and X-Ray: \$50 copay/visit	Independent lab, does not include services provided in physician's office or hospital. Limited to 4 visits per year.
	Imaging (CT/PET scans, MRIs)	\$350 copay (Subject to Maximum Plan Allowable)	Not covered if services are provided at a hospital. Limited to 3 per plan year. Preauthorization is required.
If you need drugs to treat your illness or condition	Generic drugs	20% copay /prescription for retail	Only covers generic retail drugs including COVID-19 generics. No specialty drugs or brand drugs covered (except for base contraceptive benefit).  Limited to a 30-day supply (retail); Subject to formulary.
	Preferred brand drugs	20% copay/prescription for retail	
	Non-preferred brand drugs	Not covered	
	<a href="#">Specialty drugs</a>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$350 copay (Subject to Maximum Plan Allowable)	Limited to 2 visit per plan year. Preauthorization is required.
	Physician/surgeon fees		
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$350 copay (Subject to Maximum Plan Allowable)	Limited to 2 visit per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
			be subject to reference based pricing reimbursements based on the Medicare reimbursement rate.
	<a href="#">Emergency medical transportation</a>	\$250 copay (Subject to Maximum Plan Allowable)	By land only. Limited to 2 transport per plan year
	<a href="#">Urgent care</a>	\$35 copay/visit	Not covered if provided at a hospital. Limited to 3 visits per plan year.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$350 copay per admission (Subject to Maximum Plan Allowable)	Limited to 10 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.
	Physician/surgeon fees	Included in Inpatient Hospitalization copay	Limited to visits up to 10 days per plan year.
<b>If you need mental health, behavioral health and substance abuse services</b>	Outpatient services	\$25 copay/visit	Not covered if provided at a hospital. Limited to 12 specialists visits and 10 non-specialist visits per plan year. <a href="#">Preventive services</a> are covered for mental, behavioral health or substance abuse. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Inpatient services	\$250 copay (Subject to Maximum Plan Allowable)	Limited to 10 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.
<b>If you are pregnant</b>	Office visits	Included In Professional Services <a href="#">copay</a>	See Professional Services limitations.
	Childbirth/delivery professional services	\$350 copay	Professional Services only, including standard office visits.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery facility services	\$350 copay per admission (Subject to Maximum Plan Allowable)	Considered an Inpatient Hospital Stay. Refer to limitations.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$25 copay	Limited to 20 visits per plan year. Preauthorization is required.
	<a href="#">Rehabilitation services</a>	\$50 copay	Combined limit of 12 visits per plan year with physical, speech, and occupational therapies.
	<a href="#">Habilitation services</a>	\$50 copay	
	<a href="#">Skilled nursing care</a>	Not covered	
	<a href="#">Durable medical equipment</a>	Not covered	Not covered
	<a href="#">Hospice services</a>	Not covered	Not covered
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not covered	Not covered
	Children's dental check-up	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>ACA Preventive care only</li> </ul>

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](#).

**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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[copayment\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) \$350
- [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*)

<b>Total Example Cost</b>	<b>\$13,254</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,490
<b>The total Peg would pay is</b>	<b>\$3,790</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[copayment\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) \$350
- [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*)

<b>Total Example Cost</b>	<b>\$8,017</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,050
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,052
<b>The total Joe would pay is</b>	<b>\$7,102</b>

**Mia's Simple Fracture**  
(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[copayment\]](#) \$50
- [Hospital \(facility\) \[coinsurance\]](#) \$350
- [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*)

<b>Total Example Cost</b>	<b>\$2,520</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$810
<b>The total Mia would pay is</b>	<b>\$2,110</b>