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 deductible?	$0 individual / $0 family	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 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 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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$7,350 individual / $14,700 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**, **balanced-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.mycigna.com for list of participating providers
Do you need a referral to see a specialist?	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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Specialist visit	$50 copay/visit	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Preventive care/screening/ immunization	0% coinsurance	Not covered if provided at a hospital. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limited to 1 visit per year. Subject to plan allowable.
If you have a test	Diagnostic test (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 3 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 1 per plan year. Preauthorization is required.
If you need drugs to treat your illness or condition	Generic drugs	$10 copay/prescription for retail $30 copay/prescription for mail order	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); 31-90 day supply (mail order prescription). Subject to formulary.
	Preferred brand drugs	Not covered	
	Non-preferred brand drugs	Not covered	
	Specialty drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay (Subject to Maximum Plan Allowable)	Limited to 1 visit per plan year. Preauthorization is required.
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care	$350 copay (Subject to Maximum Plan Allowable)	Limited to 1 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.
	Emergency medical transportation	$250 copay (Subject to Maximum Plan Allowable)	By land only. Limited to 1 transport per plan year
	Urgent care	$50 copay/visit	Not covered if provided at a hospital. Limited to 2 visits per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay (Subject to Maximum Plan Allowable)	Limited to 3 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 3 days per plan year.
If you need mental health, behavioral health and substance abuse services	Outpatient services	$25 copay/visit	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Inpatient services	$350 copay (Subject to Maximum Plan Allowable)	Limited to 3 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.
If you are pregnant	Office visits	Not covered	Not covered
	Childbirth/delivery professional services	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered
If you need help recovering or have	Home health care	$25 copay	Limited to 5 visits per plan year. Preauthorization is required.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	$50 copay	Combined limit of 6 visits per plan year with physical, speech, and occupational therapies.
	Habilitation services	$50 copay	
	Skilled nursing care	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered
	Hospice services	Not covered	Not covered
If your child needs dental or eye care	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 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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- ACA Preventive care only

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*)

Total Example Cost	**$13,254**

In this example, Peg would pay:

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

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*)

Total Example Cost	**$8,017**

In this example, Joe would pay:

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

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*)

Total Example Cost	**$2,520**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$810
The total Mia would pay is	**$2,110**

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