This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/individuals-families/georgia or by calling 1-866-494-2111.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers $1,000 person/ $2,000 family For out of-network providers $12,500 person/ $25,000 family Does not apply to in-network/out-of-network preventive care, eye exam/glasses for children, in-network office visit copay and urgent care visits.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for your costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, For in-network providers $6,000 person/ $12,000 family For out-of-network providers $25,000 person/ $50,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balanced-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits
Does this plan use a network of providers?	Yes. For a list of In-network providers, see www.cigna.com/ifp-providers or call 1-866-494-2111	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	30% co-insurance	----------None----------
	Specialist visit	$50 co-pay/visit	30% co-insurance	----------None----------
	Other practitioner office visit	$50 co-pay/visit	30% co-insurance	----------None----------
	Preventive care/screening/immunization	No Charge	30% co-insurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com/ifp-drug-list.	Preferred generic drugs	$4 co-pay (retail)/ $10 co-pay (home delivery)	$4 co-pay (retail)/ $10 co-pay (home delivery)	Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply.
	Non-preferred generic drugs	$10 co-pay (retail)/ $25 co-pay (home delivery)	$10 co-pay (retail)/ $25 co-pay (home delivery)	Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply.
	Preferred brand drugs	$35 co-pay (retail)/ $87 co-pay (home delivery)	$35 co-pay (retail)/ $87 co-pay (home delivery)	Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply.
	Non-preferred brand drugs	40% co-insurance (retail/home delivery)	40% co-insurance (retail/home delivery)	Coverage is limited up to a 90-day supply (retail/home delivery)
	Specialty drugs	$500 co-pay (retail)/ $425 co-pay (home delivery)	$500 co-pay (retail)/ $425 co-pay (home delivery)	Coverage is limited up to a 30-day supply (retail/home delivery)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	Non-emergency medical conditions are covered out-of-network at 40% co-insurance.
	Emergency medical transportation	20% co-insurance	20% co-insurance	
	Urgent care	$75 co-pay/visit	$75 co-pay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services – office visit Mental/Behavioral health outpatient services – all other outpatient	$50 co-pay/visit 20% co-insurance	30% co-insurance 40% co-insurance	----------None----------
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
	Substance use disorder outpatient services – office visit Substance use disorder outpatient services – all other outpatient	$50 co-pay/visit 20% co-insurance	30% co-insurance 40% co-insurance	----------None----------
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	----------None----------
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Coverage is limited to 120 visits annual max. Out-of-network cost share increases if no pre-authorization.
	Rehabilitation services	20% co-insurance	40% co-insurance	Coverage is limited to 20 visits physical and occupational therapies, 20 visits speech therapy, 30 visits respiratory therapy annual max
	Habilitation services	20% co-insurance	40% co-insurance	
	Skilled nursing care	20% co-insurance	40% co-insurance	Coverage is limited to 30 days annual max. Out-of-network cost share increases if no pre-authorization.
	Durable medical equipment	20% co-insurance	40% co-insurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Hospice service	20% co-insurance	40% co-insurance	Out-of-network cost share increases if no pre-authorization.
If your child needs dental or eye care	Eye exam	No charge	All except $45	Children up to age 19. Coverage is limited to 1 exam per year
	Glasses	No charge	All except $30 for frames/all except $32-$80 for lenses	Coverage varies by type of lens. Children up to age 19. Coverage is limited to 1 pair of glasses per year
	Dental check-up	Not covered	Not covered	Coverage is available through stand-alone dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult/child)
- Elective abortion
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adults)
- Routine foot care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.
You may also contact your state insurance department at 800-656-2298

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.
For questions about your rights, this notice, or assistance, you can contact: Georgia Department of Insurance at 800-656-2298.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,220
- Patient pays $2,320

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$1,000
Copays	$40
Coinsurance	$1,250
Limits or exclusions	$30
Total	$2,320

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,540
- Patient pays $860

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$140
Copays	$440
Coinsurance	$0
Limits or exclusions	$280
Total	$860

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.