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 1-800-Cigna24. 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 **https://www.healthcare.gov/sbc-glossary/** or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,500 person/ $11,000 family	Generally, you must pay all of 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, office visits, Urgent care visits, independent x-ray and/or lab services, Home health care, outpatient hospice, Durable medical equipment, prescription drugs and eye exam/glasses for children 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.
What is the out-of-pocket limit for this plan?	$7,900 person/ $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. See www.cigna.com or call 1-800-Cigna24 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **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	$50 copayment /visit; deductible does not apply	Not Covered	None
	Specialist visit	$65 copayment /visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge	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)	40% coinsurance (Outpatient Facility) No Charge (Independent Facility)	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cigna.com/ifp-drug-list	Generic drugs	$20 copayment (retail)/ $60 copayment (home delivery); deductible does not apply	Not Covered	Limited to up to a 30-day supply (retail) and up to a 90-day supply (home delivery).
	Preferred brand drugs	$40 copayment (retail)/ $120 copayment (home delivery); deductible does not apply	Not Covered	
	Non-preferred brand drugs	$60 copayment (retail)/ $180 copayment (home delivery); deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	You pay the same level as In-network if it is an emergency as defined in your plan, otherwise Not Covered.
	Emergency medical transportation	40% coinsurance	40% coinsurance	
	Urgent care	$75 copayment /visit; deductible does not apply	$75 copayment /visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$65 copayment / office visit; deductible does not apply and 40% coinsurance other outpatient services	Not Covered	
	Inpatient services	40% coinsurance	Not Covered	None
If you are pregnant	Office visits	40% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not Covered	
	Childbirth/delivery facility services	40% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage is limited to 42 visits annual max.
	Rehabilitation services	$65 copayment /visit; deductible does not apply	Not Covered	Coverage of physical, occupational, speech, cardiac and pulmonary therapy is limited to 60 visits annual max combined.
	Habilitation services	$65 copayment /visit; deductible does not apply	Not Covered	
	Skilled nursing care	40% coinsurance	Not Covered	None
	Durable medical equipment	No Charge	Not Covered	None
	Hospice services	40% coinsurance (Inpatient) No Charge (Outpatient)	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Children up to age 19. Coverage limited to one exam/year.
	Children's glasses	No Charge	Not Covered	Children up to age 19. Coverage limited to one pair of glasses/year.
	Children's dental check-up	No Charge	No Charge	None

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 • Cosmetic Surgery • Dental Care (Adult)	• Elective Abortion • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S.	• 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.)		
• Bariatric Surgery • Chiropractic Care	• Hearing Aids (Maximum of 1 hearing aid per ear, per calendar year)	• Private-duty nursing (If determined to be medically necessary; as part of inpatient hospital care coverage.)

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: Arizona Department of Insurance at 1-602-364-2499. 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. For more information on your rights to continue coverage, contact the insurer at 1-800-Cigna24.

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: Arizona Department of Insurance at 1-602-364-2499.

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 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 1-800-Cigna24.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-Cigna24.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-Cigna24.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-Cigna24.

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** **$5,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,500
Copayments	$50
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$7,960**

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

- **The plan's overall deductible** **$5,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,800**

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

- **The plan's overall deductible** **$5,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,310
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,510**

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