
 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 1-866-494-2111 or visit us at <https://www.cigna.com/individuals-families/policy>. 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 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$7,500 person/ \$15,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> 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> , Primary care visits, <a href="#">Urgent care</a> and eye exam/glasses for children 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 <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,150 person/ \$16,300 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="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services 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.cigna.com/ifp-providers">www.cigna.com/ifp-providers</a> or call 1-866-494-2111 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .
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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply. Virtual visit with a Cigna Telehealth Connection Physician No charge.	Not Covered	Refer to the policy for more information about Virtual Telehealth Visits.
	<a href="#">Specialist</a> visit	50% <a href="#">coinsurance</a>	Not Covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a>	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	Not Covered	None.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com/ifp-drug-list">www.cigna.com/ifp-drug-list</a>	Preferred generic drugs	50% <a href="#">coinsurance</a> (retail & home delivery)	Not Covered	Limited to up to a 30-day supply (retail) and a 90-day supply (Designated 90 day retail pharmacy/home delivery).
	Generic drugs	50% <a href="#">coinsurance</a> (retail & home delivery)	Not Covered	
	Preferred brand drugs	50% <a href="#">coinsurance</a> (retail & home delivery)	Not Covered	
	Non-preferred drugs	50% <a href="#">coinsurance</a> (retail & home delivery)	Not Covered	
	<a href="#">Specialty drugs</a> and other high cost drugs	50% <a href="#">coinsurance</a> (retail & home delivery)	Not Covered	

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)	50% <a href="#">coinsurance</a>	Not Covered	None.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not Covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	You pay the same level as In-network if it is an emergency as defined in your <a href="#">plan</a> , otherwise Not Covered.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$60 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	\$60 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a>	Not Covered	None.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <a href="#">coinsurance</a>	Not Covered	None.
	Inpatient services	50% <a href="#">coinsurance</a>	Not Covered	None.
If you are pregnant	Office visits	50% <a href="#">coinsurance</a>	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a>	Not Covered	

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 help recovering or have other special health needs	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a>	Not Covered	None.
	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	Coverage of physical, occupational and chiropractic therapy is limited to 30 combined visits annual max. Speech therapy is limited to 30 visits annual max.
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a>	Not Covered	Coverage is limited to 30 visits annual max.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	Not Covered	Coverage is limited to 60 days annual max.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not Covered	None.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a>	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	Not Covered	Not Covered	Coverage is available through a stand-alone dental policy.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> 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>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care (Adult)</li> <li>• Elective Abortion</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> </ul>

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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|---|---|---|
| <ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care</li></ul> | <ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility Treatment (excludes in vitro, AI etc.)</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Weight Loss Programs</li></ul> |
|---|---|---|

**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: North Carolina Department of Insurance at 1-855-408-1212. 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](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.

**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: North Carolina Department's Health Insurance Smart NC Program at 1-855-408-1212.

**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?** N/A.

**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, kwijigo holne' 1-866-494-2111.

-----*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](#) \$7,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$7,500
Copayments	\$50
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$8,160</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$6,050
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$6650</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,590
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,690</b>