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 deductible?	$6,000 person/ $12,000 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 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?	Yes. Prescription drugs. $1,500 person/$3,000 family.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,150 person/ $16,300 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, penalties for failure to obtain preauthorization 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.
Will you pay less if you use a network provider?	Yes. See www.cigna.com/ifp-providers or call 1-866-494-2111 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 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 provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance; Virtual visit with a Cigna Telehealth Connection Physician No charge	Not Covered	Refer to the policy for more information about Virtual Telehealth Visits.
	Specialist visit	50% coinsurance	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)	50% coinsurance	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not Covered	None.
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	50% coinsurance (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% coinsurance (retail/home delivery)	Not Covered	
	Preferred brand drugs	50% coinsurance (retail/home delivery)	Not Covered	
	Non-preferred drugs	50% coinsurance (retail/home delivery)	Not Covered	
	Specialty drugs and other high cost drugs	50% coinsurance (retail) /40% coinsurance (home delivery)	Not Covered	Limited to up to a 30-day supply (retail) and a 30-day supply (Designated 90 day retail pharmacy/home delivery).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not Covered	None.
	Physician/surgeon fees	50% 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 immediate medical attention	Emergency room care	50% coinsurance	50% 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	50% coinsurance	50% coinsurance	
	Urgent care	50% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not Covered	None.
	Physician/surgeon fees	50% coinsurance	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	Not Covered	None.
	Inpatient services	50% coinsurance	Not Covered	None.
If you are pregnant	Office visits	50% coinsurance	Not Covered	Cost sharing does not apply for 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	50% coinsurance	Not Covered	
	Childbirth/delivery facility services	50% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	Not Covered	Coverage is limited to a maximum of 30 visits per year.
	Rehabilitation services	50% coinsurance	Not Covered	Coverage of physical, occupational and speech therapy is limited to a combined maximum of 20 visits per year. Cardiac and Pulmonary limited to a combined maximum of 5 visits per year.
	Habilitation services	50% coinsurance	Not Covered	Coverage of physical, occupational and speech therapy is limited to a combined maximum of 20 visits per year.
	Skilled nursing care	50% coinsurance	Not Covered	Coverage is limited to a maximum of 30 days per year.
	Durable medical equipment	50% coinsurance	Not Covered	None.
	Hospice services	50% 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 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	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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care
- Elective abortion
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Reconstructive surgery

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: Utah Insurance Department at 1-800-439-3805. 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 1-866-494-2111.

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 the Utah Insurance Department at 1-800-439-3805.

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, kwiijigo 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	$6,000
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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$8,210

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

The plan's overall deductible	$6,000
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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$4,900

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

The plan's overall deductible	$6,000
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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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