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, go online at www.cigna.com/sp. 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?	For in-network providers: $150/individual or $250/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. In-network preventive care & immunizations, office visits, diagnostic test, prescription drugs, emergency room visits, urgent care facility visits.	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?	For in-network providers: $1,500/individual or $3,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	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.

Important Questions	Answers	Why This Matters:
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 **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
		In-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	$20 copay/visit Onsite Clinic: No charge/visit Deductible does not apply	Not covered	In-network Convenience Care Clinic - $10 copay/visit
	Specialist visit	$50 copay/visit Deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	Not covered	None None None 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance/x-ray at Hospital Based or Affiliated $100 copay/x-ray at Non-Hospital Based** No charge/blood work** No charge/independent lab** **Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance/Hospital Based or Affiliated $100 copay/Non-Hospital Based** **Deductible does not apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Generic drugs (Tier 1)	No charge/preventive (retail 30 days) No charge/preventive (retail 90 days) No charge/preventive (home delivery 90 days) $15 copay/prescription (retail 30 days) $30 copay/prescription (retail 90 days) $30 copay/prescription (home delivery 90 days) $15 copay/ADD & ADHD (retail 30 days) $30 copay/ADD & ADHD (retail 90 days) $30 copay/ADD & ADHD (home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs (Tier 2)	$40 copay/prescription (retail 30 days) $80 copay/prescription (retail 90 days) $80 copay/prescription (home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$125 copay/prescription (retail 30 days) $315 copay/prescription (retail 90 days) $315 copay/prescription (home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance/Hospital Based or Affiliated $100 copay/Non-Hospital Based** **Deductible does not apply	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$300 copay/visit** $150 copay/visit at JMH Facilities (Memorial, North & South)** **Deductible does not apply	$300 copay/visit** $150 copay/visit at JMH Facilities (Memorial, North & South)** **Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None
	Urgent care	$40 copay/visit Deductible does not apply	$40 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit** No charge/all other services** **Deductible does not apply	Not covered	None
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	No Charge Deductible does not apply	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge Deductible does not apply	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Home health care	30% coinsurance	Not covered	16 hour maximum per day
	Rehabilitation services	$35 copay/visit for Physical therapy** $20 copay/PCP visit for Speech and Occupational therapies** $50 copay/ Specialist visit for Speech and Occupational therapies** $45 copay/visit for Pulmonary rehab and Cardiac rehab services** $45 copay/visit for Chiropractic care** **Deductible does not apply	Not covered	Coverage is limited to annual max of: 40 days for Pulmonary rehab services; 40 days for Cardiac rehab services; 40 days for Physical therapy; 40 days for Speech therapy; 40 days for Occupational therapy; 30 days for Chiropractic care services Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$35 copay/visit for Physical therapy** $20 copay/PCP visit for Speech and Occupational therapies** $50 copay/ Specialist visit for Speech and Occupational therapies** $45 copay/visit for Pulmonary rehab and Cardiac rehab services** **Deductible does not apply	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited to 90 days annual max.
	Durable medical equipment	30% coinsurance	Not covered	None
	Hospice services	30% coinsurance/inpatient; 30% coinsurance/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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 • Cosmetic surgery • Dental care (Adult)	• Dental care (Children) • Eye care (Children) • 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.)		
• Chiropractic care (30 days)	• Hearing aids	• Infertility treatment

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------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** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$20
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,490**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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

Plan Name: SureFit **Ben Ver:** 19 **Plan ID:** 10547309