



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 : \$600/individual or \$1,800/family For mental health and substance abuse out-of-network providers : \$650 individual/\$1,950 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 , 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?	Yes; \$100 per person for retail brand prescription drugs.	You must pay all of 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?	For in-network providers : \$3,000/individual or \$6,000/family For mental health and substance abuse out-of-network providers : \$6,000/individual or \$12,000/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 <u>network provider</u> ?	Yes. See www.cigna.com or call 1-800-440-DUKE (3853) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>Specialist</u> ?	No.	You can see the <u>Specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	Not covered	<u>Medically Necessary</u>
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit <u>Deductible</u> does not apply	Not covered	Chiropractic care \$75 <u>copay</u> /visit <u>Medically Necessary</u>
	<u>Preventive care/ screening/ immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after deductible/x-ray 10% <u>coinsurance</u> after deductible/blood work No charge/independent lab** ** <u>Deductible</u> does not apply	Not covered	<u>Medically Necessary</u>
	Imaging (CT/PET scans, MRIs)	\$150 <u>copay</u> per day	Not covered	<u>Medically Necessary</u>

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.express-scripts.com	Generic drugs (Tier 1)	\$15 copay /prescription after \$100 deductible (retail up to 34 day supply), \$25 copay /prescription after \$100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay . You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorization may apply.
	Preferred brand drugs (Tier 2)	\$50 copay /prescription after \$100 deductible (retail up to 34 day supply), \$130 copay /prescription after \$100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay . You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorization may apply.
	Non-preferred brand drugs (Tier 3)	\$70 copay /prescription after \$100 deductible (retail up to 34 day supply), \$180 copay /prescription after \$100 deductible (home delivery up to 90 day supply)	Your reimbursement will be the contracted rate less the copay . You pay the difference between cost and reimbursement.	After 3rd retail fill of long-term medications the mail order program or Duke pharmacies must be used for coverage. Step therapy and/or pre-authorization may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Medically Necessary
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Medically Necessary
If you need immediate medical attention	Emergency room care	\$250 copay /visit Deductible does not apply	\$250 copay /visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. Medically Necessary
	Emergency medical transportation	\$250 per day Deductible does not apply	\$250 per day Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible . Services for MH/SA diagnoses will be payable according to Emergency room care benefits. Medically Necessary

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)	
	Urgent care	\$50 copay /visit Deductible does not apply	\$50 copay /visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Precertification required. WakeMed considered participating only for obstetrics, rehabilitation and most pediatric admissions.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit** 10% coinsurance /all other services** ** Deductible does not apply	30% coinsurance after deductible/office visit 30% coinsurance after deductible/all other services	Up to 20 visits per calendar year for non-par providers, combined with substance use disorder. Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance after deductible	\$900 deductible /admission, plus 30% coinsurance after deductible	Precertification required. Up to 20 days per calendar year for non-par providers, combined with substance use disorder. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge \$25 copay /PCP first visit \$75 copay / Specialist first visit	Not covered	Primary care or Specialist benefit levels apply for initial visit (\$25 copay Primary care or \$75 copay Specialist) to confirm pregnancy. Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No charge	Not covered	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 facility services	10% coinsurance after deductible	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	\$25 copay /visit** ** Deductible does not apply	Not covered	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	\$75 copay / Specialist visit** ** Deductible does not apply	Not covered	Coverage is limited to annual max of: Unlimited days for Pulmonary rehab; 40 days for Cognitive therapy, Chiropractic care services, Physical and Occupational therapies; 20 days for Speech therapy Medically Necessary
	Habilitation services	\$75 copay / Specialist visit** ** Deductible does not apply	Not covered	Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Hospice services	No charge/inpatient services No charge/outpatient services	Not covered	Coverage is limited to 60 days annual max.
If your child needs dental or eye care	Children's eye exam	\$55 copay /visit	Not covered	Limited to one routine eye exam per calendar year
	Children's glasses	Not covered	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)	
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (combined with [Rehabilitation Services](#))
- Hearing aids (2 devices per 36 months, through age 22)
- Routine eye care (Adult)
- Eye care (Children)
- Infertility treatment - Diagnosis only. Patient copays apply. COH, IVF, and other types of artificial conception are excluded.

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: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: 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. Additionally, a consumer assistance program can help you file your [appeal](#). Contact: North Carolina Department of Insurance at (855) 408-1212.

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, kwijjigo 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](#) \$600
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$600
Copayments	\$40
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$1,560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$1,040

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$300
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.



If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare

Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).a

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 (聽障專線：請撥 711) 。

Vietnamese – XIN LUU Ý: Quý vị được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 디얼 711) 번으로 전화해주십시오.a

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

– برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقةكم الشخصية. **Arabic**
او اتصل ب 711 (TTY) 1.800.244.6224 .

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار هگیری کنید).