



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](http://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 1-866-494-2111 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">in-network providers</a> : \$1,500/individual or \$3,000/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> .                                                                                                                                                                                                           |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, <a href="#">diagnostic test</a> , imaging services, in-network inpatient hospital facility, in-network outpatient hospital facility, <a href="#">prescription drugs</a> , emergency room visits, <a href="#">urgent care</a> facility visits. | 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> .                                                                      |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. \$660 for in-network outpatient hospital visit; \$1,000 per admission for in-network hospital stay<br>There are no other specific <a href="#">deductibles</a> .                                                                                                                                                          | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">in-network providers</a> : \$6,000/individual or \$12,000/family<br>Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>                                                                                                                                                              | 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.                                                                                                                                                                                                                                                                                                                                                            |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.cigna.com">www.cigna.com</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. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |



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<br>(You will pay the least)                                                                                                                                                                                     | Out-of-Network Provider<br>(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         | \$40 <a href="#">copay</a> /office visit**<br>No charge/MDLIVE visit**<br><br>** <a href="#">Deductible</a> does not apply                                                                                                          | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | <a href="#">Specialist</a> visit                         | \$80 <a href="#">copay</a> /office visit**<br>No charge/MDLIVE visit**<br><br>** <a href="#">Deductible</a> does not apply                                                                                                          | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | <a href="#">Preventive care/ screening</a> /immunization | No charge<br><a href="#">Deductible</a> does not apply                                                                                                                                                                              | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. 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)      | No charge<br><a href="#">Deductible</a> does not apply                                                                                                                                                                              | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | Imaging (CT/PET scans, MRIs)                             | \$500 scan per day <a href="#">copay</a> at an outpatient facility**<br>\$500 scan per day <a href="#">copay</a> in the office**<br>** <a href="#">Deductible</a> does not apply                                                    | Not covered                                        | None                                                                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> is available at | Generic drugs (Tier 1)                                   | \$10 <a href="#">copay</a> /prescription (retail 30 days), \$25 <a href="#">copay</a> /prescription (retail 90 days); \$30 <a href="#">copay</a> /prescription (home delivery 90 days)<br><a href="#">Deductible</a> does not apply | Not covered                                        | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a> . Certain limitations may apply, including, for example: prior |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                     |                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                                                                                       | Out-of-Network Provider<br>(You will pay the most)                              |                                                                                                                                                                                                                                                                |
| <a href="http://www.cigna.com">www.cigna.com</a>                          | Preferred brand drugs (Tier 2)                   | \$35 <a href="#">copay</a> /prescription (retail 30 days), \$88 <a href="#">copay</a> /prescription (retail 90 days); \$105 <a href="#">copay</a> /prescription (home delivery 90 days)<br><a href="#">Deductible</a> does not apply  | Not covered                                                                     | authorization, step therapy, quantity limits.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
|                                                                           | Non-preferred brand drugs (Tier 3)               | \$70 <a href="#">copay</a> /prescription (retail 30 days), \$175 <a href="#">copay</a> /prescription (retail 90 days); \$210 <a href="#">copay</a> /prescription (home delivery 90 days)<br><a href="#">Deductible</a> does not apply | Not covered                                                                     |                                                                                                                                                                                                                                                                |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$660 <a href="#">deductible</a> /admission<br><a href="#">Deductible</a> does not apply                                                                                                                                              | Not covered                                                                     | None                                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No charge                                                                                                                                                                                                                             | Not covered                                                                     | None                                                                                                                                                                                                                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$500 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                                                                                                                                                       | \$500 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply | Per visit <a href="#">copay</a> is waived if admitted. Out-of-network services are paid at the in-network cost share.                                                                                                                                          |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                                                                                                                                                                                             | No charge                                                                       | Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> . Services for MH/SA diagnoses will be payable according to <a href="#">Emergency room care</a> benefits.                                           |
|                                                                           | <a href="#">Urgent care</a>                      | \$80 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                                                                                                                                                        | Not covered<br><a href="#">Deductible</a> does not apply                        | None                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$1,000 <a href="#">deductible</a> /admission<br><a href="#">Deductible</a> does not apply                                                                                                                                            | Not covered                                                                     | None                                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No charge                                                                                                                                                                                                                             | Not covered                                                                     | None                                                                                                                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge/office visit**<br>No charge/all other services**<br>** <a href="#">Deductible</a> does not apply                                                                                                                            | Not covered                                                                     | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                 |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)                                                                                                                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | Inpatient services                        | \$1,000 <a href="#">deductible</a> /admission<br><a href="#">Deductible</a> does not apply                                                                                                                | Not covered                                        | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you are pregnant                                            | Office visits                             | No charge                                                                                                                                                                                                 | Not covered                                        | Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.<br><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .<br>Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                |
|                                                                | Childbirth/delivery professional services | No charge                                                                                                                                                                                                 | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | Childbirth/delivery facility services     | \$1,000 <a href="#">deductible</a> /admission<br><a href="#">Deductible</a> does not apply                                                                                                                | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No charge                                                                                                                                                                                                 | Not covered                                        | Coverage is limited to 100 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | <a href="#">Rehabilitation services</a>   | \$40 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**<br><br>\$40 <a href="#">copay</a> /visit for Chiropractic care**<br>** <a href="#">Deductible</a> does not apply | Not covered                                        | Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services. Additional coverage is available for Physical, Occupational, Chiropractic Therapy and Acupuncture Services when provided as an alternative to opioid treatment for chronic pain management and provider notifies the plan of the treatment program.<br><br>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<br>(You will pay the least)                                                                                          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                           |
|                                        | <a href="#">Habilitation services</a>     | \$40 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**<br>** <a href="#">Deductible</a> does not apply | Not covered                                        | Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
|                                        | <a href="#">Skilled nursing care</a>      | No charge                                                                                                                                | Not covered                                        | Coverage is limited to 60 days annual max.                                                                                                                                                                                                                |
|                                        | <a href="#">Durable medical equipment</a> | No charge                                                                                                                                | Not covered                                        | None                                                                                                                                                                                                                                                      |
|                                        | <a href="#">Hospice services</a>          | No charge/inpatient services<br>No charge/outpatient services                                                                            | Not covered                                        | None                                                                                                                                                                                                                                                      |
| If your child needs dental or eye care | Children's eye exam                       | No charge                                                                                                                                | Not covered                                        | \$30 max/24 months                                                                                                                                                                                                                                        |
|                                        | 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 <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>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>                                                                        | <ul style="list-style-type: none"> <li>Dental care (Children)</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside of the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |                                                                                                                                                       |                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture (12 visits)</li> <li>Chiropractic care (20 visits)</li> </ul>                             | <ul style="list-style-type: none"> <li>Hearing aids (2 (one per ear) devices per 36 months, through age 17)</li> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult - \$30 max/24 months)</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: Cigna at 1-866-494-2111, Colorado Division of Insurance at 1-800-930-3745 and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 1-866-494-2111. You may also contact Colorado Division of Insurance at 1-800-930-3745.

### **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 1-866-494-2111.

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, kwijjigo 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](#) \$1,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$2,500        |
| <a href="#">Copayments</a>        | \$50           |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Peg would pay is</b> | <b>\$2,570</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$800        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$40         |
| <b>The total Joe would pay is</b> | <b>\$840</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$980          |
| <a href="#">Copayments</a>        | \$900          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,880</b> |

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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).

**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 LƯU Ý: Quý vị được 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 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711) 번으로 전화해주시십시오.

**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).

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

**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 شماره ای 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 شماره گیری کنید).