


# 2020 OAPP Premier Plan SBC



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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>For <a href="#">in-network providers</a>: <b>\$250</b>/individual or <b>\$500</b>/family;                      For <a href="#">out-of-network providers</a>: <b>\$1,000</b>/individual or <b>\$2,000</b>/family</p>	<p>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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-network <a href="#">preventive care</a> &amp; immunizations, office visits, in-network <a href="#">prescription drugs</a>, emergency room visits, <a href="#">urgent care</a> facility visits, employee assistance program.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. \$200 annual deductible for External Prosthetic Appliance.</p>	<p>You do have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For <a href="#">in-network providers</a> <b>\$5,000</b>/individual or <b>\$10,000</b>/family;                      For <a href="#">out-of-network providers</a> <b>\$10,000</b>/individual or <b>\$20,000</b>/family                      Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a></p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge/visit** No charge/screening** No charge/immunizations**  ** <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> /visit 50% <a href="#">coinsurance</a> /screening 50% <a href="#">coinsurance</a> /immunizations	None None None  You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need 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)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a></p>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail 30 days), \$10 <a href="#">copay</a> /prescription (retail 90 days); \$10 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	<p>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.</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail 30 days), \$60 <a href="#">copay</a> /prescription (retail 90 days); \$60 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$55 <a href="#">copay</a> /prescription (retail 30 days), \$165 <a href="#">copay</a> /prescription (retail 90 days); \$165 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> /visit, plus 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Per visit <a href="#">copay</a> is waived for non-surgical procedures.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit, plus 10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$200 <a href="#">copay</a> /visit, plus 10% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> /admission, plus 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay/office visit** 10% coinsurance/all other services **Deductible does not apply	50% <a href="#">coinsurance</a> /office visit 50% <a href="#">coinsurance</a> /all other services	50% penalty if no percent of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	\$500 copay/admission, plus 10% coinsurance	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Office visits	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>		
If you are pregnant	Childbirth/delivery facility services	\$500 copay/admission, plus 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Coverage is limited to 90 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /PCP visit** \$40 <a href="#">copay</a> /Specialist visit** ** <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> /PCP visit 50% <a href="#">coinsurance</a> /Specialist visit	50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for <a href="#">Rehabilitation services</a> ; 36 days for Cardiac rehab services; 30 days annual max for Chiropractic care services
				Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
				50% penalty for failure to precertify speech therapy services.
				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.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Coverage is limited to 100 days annual max.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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)	
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> /inpatient; 10% <a href="#">coinsurance</a> /outpatient services	50% <a href="#">coinsurance</a> /inpatient; 50% <a href="#">coinsurance</a> /outpatient services	50% penalty for failure to precertify inpatient <a href="#">hospice services</a> .
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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Eye care (Children)</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>• Bariatric Surgery (in-network only)</li> <li>• Chiropractic care (30 days)</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: 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](http://www.HealthCare.gov), 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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions 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](http://www.dol.gov/ebsa/healthreform).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet 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, kwijigo 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** \$250
- **Specialist copayment** \$40
- **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*)

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

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$500
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,960</b>

**Managing Joe's type 2 Diabetes**

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

- **The plan's overall deductible** \$250
- **Specialist copayment** \$40
- **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*)

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

<i>Cost Sharing</i>	
Deductibles	\$130
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$1,230</b>

**Mia's Simple Fracture**

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

- **The plan's overall deductible** \$250
- **Specialist copayment** \$40
- **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*)

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

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$640</b>

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

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**2020**  
**OAP Classic Plan SBC**

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Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>For <a href="#">in-network providers</a>: <b>\$500</b>/individual or <b>\$1,000</b>/family;                      For <a href="#">out-of-network providers</a>: <b>\$1,000</b>/individual or <b>\$2,000</b>/family</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. In-network <a href="#">preventive care</a> &amp; immunizations, office visits, in-network <a href="#">prescription drugs</a>, emergency room visits, <a href="#">urgent care</a> facility visits, employee assistance program.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Yes. \$200 annual deductible for External Prosthetic Appliance.</p>	<p>You do have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">in-network providers</a> <b>\$6,350</b>/individual or <b>\$12,700</b>/family;                      For <a href="#">out-of-network providers</a> <b>\$10,000</b>/individual or <b>\$20,000</b>/family                      Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a></p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Preventive care/ screening/ immunization</a>	No charge/visit**	50% <a href="#">coinsurance</a> /visit	None
		No charge/screening**	50% <a href="#">coinsurance</a> /screening	None
		No charge/immunizations**	50% <a href="#">coinsurance</a> /immunizations	None
		** <a href="#">Deductible</a> does not apply		You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need 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)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a></p>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail 30 days), \$10 <a href="#">copay</a> /prescription (retail 90 days); \$10 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	<p>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.</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail 30 days), \$60 <a href="#">copay</a> /prescription (retail 90 days); \$60 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$55 <a href="#">copay</a> /prescription (retail 30 days), \$165 <a href="#">copay</a> /prescription (retail 90 days); \$165 <a href="#">copay</a> /prescription (home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$300 <a href="#">copay</a> /visit, plus 20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Per visit <a href="#">copay</a> is waived for non-surgical procedures.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	\$250 <a href="#">copay</a> /visit, plus 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> /admission, plus 20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	50% coinsurance/office visit 50% coinsurance/all other services	50% penalty if no precept of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	\$500 copay/admission, plus 20% coinsurance	50% coinsurance	50% penalty for no precertification.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	\$500 copay/admission, plus 20% coinsurance	50% coinsurance	



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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Coverage is limited to 90 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay/PCP visit</a> **	50% <a href="#">coinsurance/PCP visit</a>	50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for <a href="#">Rehabilitation services</a> ; 36 days for Cardiac rehab services; 30 days annual max for Chiropractic care services
		\$50 <a href="#">copay/Specialist visit</a> ** ** <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance/Specialist visit</a>	
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay/PCP visit</a> **	50% <a href="#">coinsurance/PCP visit</a>	50% penalty for failure to precertify speech therapy services.  Services are covered when Medically Necessary to treat a mental health condition (e.g. autism).
		\$50 <a href="#">copay/Specialist visit</a> ** ** <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance/Specialist visit</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Coverage is limited to 100 days annual max.
<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.	

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)	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> /inpatient; 20% <a href="#">coinsurance</a> /outpatient services	50% <a href="#">coinsurance</a> /inpatient; 50% <a href="#">coinsurance</a> /outpatient services	50% penalty for failure to precertify inpatient <a href="#">hospice services</a> .
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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Eye care (Children)</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>• Bariatric Surgery (in-network only)</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: 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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your plan. For questions 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](http://www.dol.gov/ebsa/healthreform).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet 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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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](#) \$500
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost**      **\$12,800**

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$3,310</b>

**Managing Joe's type 2 Diabetes**

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

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost**      **\$7,400**

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$130
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$1,230</b>

**Mia's Simple Fracture**

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

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$50
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost**      **\$1,900**

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

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

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**2020**

**Choice Fund OAP HSA Plan SBC**



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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>For in-network providers: <b>\$1,500</b>/individual or <b>\$3,000</b>/family;                      For out-of-network providers: <b>\$3,000</b>/individual or <b>\$6,000</b>/family                      Combined medical/behavioral and pharmacy <a href="#">deductible</a>  <a href="#">Deductible</a> per individual applies when the employee is the only individual covered under the <a href="#">plan</a>.                      Amount your employer contributes to your account: Up to <b>\$750</b>/individual or <b>\$1,250</b>/family.</p>	<p>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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-network <a href="#">preventive care</a> &amp; immunizations, employee assistance program.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For <a href="#">in-network providers</a> <b>\$6,000</b>/individual or <b>\$12,000</b>/family (no more than <b>\$6,000</b> per individual in the family);                      For <a href="#">out-of-network providers</a> <b>\$13,100</b>/individual or <b>\$26,200</b>/family (no more than <b>\$26,200</b> per individual in the family)                      Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a></p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>



Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	None
If you visit a health care <a href="#">provider's office or clinic</a>	No charge/visit**	No charge/visit**	Not covered/visit	None
	No charge/screening**	No charge/screening**	50% <a href="#">coinsurance</a> /screening	None
If you have a test	No charge/immunizations**	No charge/immunizations**	Not covered/immunizations	None
	<a href="#">Preventive care/ screening/ immunization</a>	** <a href="#">Deductible</a> does not apply		You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need 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)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a></p>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail 30 days), \$10 <a href="#">copay</a> /prescription (retail 90 days); \$10 <a href="#">copay</a> /prescription (home delivery 90 days)	50% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery)	<p>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.</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail 30 days), \$60 <a href="#">copay</a> /prescription (retail 90 days); \$60 <a href="#">copay</a> /prescription (home delivery 90 days)	50% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	\$55 <a href="#">copay</a> /prescription (retail 30 days), \$165 <a href="#">copay</a> /prescription (retail 90 days); \$165 <a href="#">copay</a> /prescription (home delivery 90 days)	50% <a href="#">coinsurance</a> /prescription (retail); Not covered (home delivery)	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
<p><b>If you have a hospital stay</b></p>	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Outpatient services	20% <a href="#">coinsurance</a> /office visit	50% <a href="#">coinsurance</a> /office visit	50% penalty if no percent of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% <a href="#">coinsurance</a> /all other services	50% <a href="#">coinsurance</a> /all other services	50% penalty for no precertification.

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 are pregnant	Office visits	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification. Coverage is limited to 90 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> /PCP visit	50% <a href="#">coinsurance</a> /PCP visit	50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 90 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
		20% <a href="#">coinsurance</a> /Specialist visit	50% <a href="#">coinsurance</a> /Specialist visit	
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> /PCP visit	50% <a href="#">coinsurance</a> /PCP visit	Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. 50% penalty for failure to precertify speech therapy services.
		20% <a href="#">coinsurance</a> /Specialist visit	50% <a href="#">coinsurance</a> /Specialist visit	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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. 50% penalty for no precertification. Coverage is limited to 100 days annual max.
		20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for no precertification.
		20% <a href="#">coinsurance</a> /inpatient; 20% <a href="#">coinsurance</a> /outpatient services	50% <a href="#">coinsurance</a> /inpatient; 50% <a href="#">coinsurance</a> /outpatient services	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% penalty for failure to precertify inpatient <a href="#">hospice services</a> .

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 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:**

<p><b>Services Your Plan 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>.)</b></p> <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Eye care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
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<p><b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b></p> <ul style="list-style-type: none"> <li>• Bariatric Surgery (in-network only)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (combined with Rehabilitation Services)</li> </ul>
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### **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](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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your plan. For questions 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](http://www.dol.gov/ebsa/healthreform).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet 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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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](#) \$1,500
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,800

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$20
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$3,730</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 coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,400

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$600
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$2,390</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$1,900

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,590</b>

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





**Cigna Vision**  
**City of Richmond & Richmond Public Schools**  
**C1 - Standard PPO Comprehensive Plan**

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **
Exam Copay	\$15	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to \$45	12 months
Materials Copay	\$0	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period)			
Single Vision	Covered 100% after Copay	Up to \$32	12 months
Lined Bifocal	Covered 100% after Copay	Up to \$55	12 months
Lined Trifocal	Covered 100% after Copay	Up to \$65	12 months
Lenticular	Covered 100% after Copay	Up to \$80	12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period)			
Elective	Up to \$100	Up to \$87	12 months
Therapeutic	Covered 100%	Up to \$210	12 months
Frame Retail Allowance (one per frequency period)	Up to \$100	Up to \$55	24 months

\*\* Your Frequency Period begins on January 1 (Calendar year basis)

**Definitions:**

**Copay:** the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).

**Coinsurance:** the percentage of charges Cigna will pay. Customer is financially responsible for the balance.

**Allowance:** the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.

**Materials:** eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

**In-Network Coverage Includes:**

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 18 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings\* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;



- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

\* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

**Healthy Rewards® - Vision Network Savings Program:**

- When you see a Cigna Vision Network Eye Care Professional\*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

**What's Not Covered:**

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

**How to use your Cigna Vision Benefits**

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

**1. Finding a doctor**

There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision



customer service representative.

**2. Schedule an appointment**

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

**3. Out-of-network plan reimbursement**

**How to use your Cigna Vision Benefits**

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- Go to **Cigna.com** and go to Forms, Vision Forms
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Healthy Rewards® - Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.



## DISCRIMINATION IS AGAINST THE LAW

### Vision coverage

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

Cigna:

- 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 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](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO 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](mailto: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 <http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company and Connecticut General Life Insurance Company. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. Call 1.877.478.7557 (TTY: 800.428.4833). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.478.7557 (TTY: 800.428.4833).

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### Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.877.478.7557 (TTY: 800.428.4833).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.877.478.7557 (TTY: 800.428.4833).

**Chinese** – 注意：我們可為您免費提供語言協助服務。請致電 1.877.478.7557（聽障專線：800.428.4833）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.877.478.7557 (TTY: 800.428.4833).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.478.7557 (TTY: 800.428.4833)번으로 전화해주시십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.877.478.7557 (TTY: 800.428.4833).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.478.7557 (линия ТТУ телетайп: 800.428.4833).

**Arabic** – ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.478.7557 (رقم هاتف الصم والبكم: 800.428.4833).

**French Creole** – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.478.7557 (TTY: 800.428.4833).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.877.478.7557 (ATS: 800.428.4833).

**Portuguese** – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.877.478.7557 (TTY: 800.428.4833).

**Polish** – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 877 478 7557 (TTY: 800.428.4833).

**Japanese** – 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1.877.478.7557 (TTY: 800.428.4833) まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.478.7557 (TTY: 800.428.4833).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.478.7557 (TTY: 800.428.4833).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. با شماره 1.877.478.7557 تماس بگیرید (شماره تلفن ویژه ناشنوايان: 800.428.4833).



**Cigna Dental Benefit Summary**  
**City of Richmond**  
**Plan Renewal Date: 01/01/2020**



Insured by: Cigna Health and Life Insurance Company

Receiving regular dental care can not only catch minor problems before they become major and expensive to treat - it may even help improve your overall health. Gum disease is increasingly being linked to complications for pre-term birth, heart disease, stroke, diabetes, osteoporosis and other health issues. That's why this dental plan includes **Cigna Dental WellnessPlus<sup>SM</sup>** features. When you or your family members receive any preventive care service in one plan year, the annual dollar maximum will increase in the following plan year. When you or your family members remain enrolled in the plan and continue to receive preventive care, the annual dollar maximum will increase in the following plan year, until it reaches the level specified below. Please refer to your plan materials for additional information on this plan feature.

<b>Cigna Dental PPO</b>				
<b>Network Options</b>	<b>In-Network: Total Cigna DPPO Network</b>		<b>Out-of-Network: Non-Network Reimbursement</b>	
<b>Reimbursement Levels</b>	Based on Contracted Fees		Maximum Reimbursable Charge	
<b>Progressive Maximum Benefit:</b> Progressive Benefit Year 2: Increase contingent upon receiving Preventive Services in Plan Year 1. Progressive Benefit Year 3: Increase contingent upon receiving Preventive Services in Plan Years 1 and 2. Progressive Benefit Year 4: Increase contingent upon receiving Preventive Services in Plan Years 1, 2 and 3.				
<b>Calendar Year Benefits Maximum</b> Applies to: Class I, II & III expenses	Year 1: \$1,500 Year 2: \$1,600 Year 3: \$1,700 Year 4: \$1,800		Year 1: \$1,000 Year 2: \$1,100 Year 3: \$1,200 Year 4: \$1,300	
<b>Calendar Year Deductible</b> Individual Family	\$50 \$150		\$50 \$150	
<b>Benefit Highlights</b>	<b>Plan Pays</b>	<b>You Pay</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Class I: Diagnostic &amp; Preventive</b> Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
<b>Class II: Basic Restorative</b> Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible
<b>Class III: Major Restorative</b> Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
<b>Class IV: Orthodontia</b> Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: \$1,000	50% No Deductible	50% No Deductible	50% No Deductible	50% No Deductible
<b>Benefit Plan Provisions:</b>				
<b>In-Network Reimbursement</b>	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.			
<b>Non-Network Reimbursement</b>	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.			

<b>Cross Accumulation</b>	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
<b>Calendar Year Benefits Maximum</b>	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
<b>Calendar Year Deductible</b>	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
<b>Pretreatment Review</b>	Pretreatment review is available on a voluntary basis when dental work in excess of \$200 is proposed.
<b>Alternate Benefit Provision</b>	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
<b>Oral Health Integration Program (OHIP)</b>	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to <a href="http://www.mycigna.com">www.mycigna.com</a> or call customer service 24/7 at 1.800.CIGNA24.
<b>Timely Filing</b>	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
<b>Benefit Limitations:</b>	
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	1 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partial	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
<b>Benefit Exclusions:</b>	
Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.



# DENTAL INSURANCE THAT FITS



## Cigna Dental Care Plan<sup>1</sup>

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND HEALTH SERVICES AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

Regular dental care is important for a healthy smile. And a healthy body. With the Cigna Dental Care<sup>®</sup> plan, you get comprehensive dental coverage that's easy to use. At a wallet-friendly price. Now that's something to smile about.

This overview shows you a sampling of covered services. And what your plan pays. For a full listing of covered services, please call Customer Service at **800.Cigna24 (800.244.6224)**.

### Get the most value from your plan

With your Cigna Dental Care plan, some preventive services are covered at 100%. (See chart below.) Your plan also covers many other dental services that help your mouth stay healthy.

Your Cigna Dental Care plan is a **copayment plan**. Here's how it works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then **you pay a fixed portion** of that cost, in addition to any allowable charge for upgraded materials (such as gold, high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). You'll also be charged a \$5 fee each time you visit your dentist. And your plan pays the rest. There are **no annual maximums** and **no deductibles!**

Review your plan materials for more information about how your plan works. If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the "Enrollment Information" prompt.

Sampling of covered procedures	WHAT YOU'LL PAY <sup>2</sup>	
	With Cigna Dental Care	Without dental coverage
Adult cleaning (two per calendar year – each at \$0) (additional cleanings available at \$41.00 each)	\$0	\$68–\$155 each
Child cleaning (two per calendar year – each at \$0) (additional cleanings available at \$30.00 each)	\$0	\$53–\$121 each
Periodic oral evaluation	\$0	\$40–\$90
Comprehensive oral evaluation	\$0	\$63–\$143
Topical fluoride (two per calendar year – each at \$0) (additional topical fluoride available at \$15.00 each)	\$0	\$28–\$63 each
X-rays – (bitewings) 2 films	\$0	\$33–\$75
X-rays – panoramic film	\$0	\$83–\$189
Sealant – per tooth	\$10.00	\$41–\$94
Amalgam filling (silver colored) – 2 surfaces	\$10.00	\$117–\$266
Composite filling (tooth – colored) – 1 surface, Anterior	\$15.00	\$118–\$270
Molar root canal (excluding final restoration)	\$280.00	\$840–\$1,914
Comprehensive orthodontic treatment of the adolescent dentition – Banding	\$400.00	\$967–\$2,203
Periodontal (gum) scaling & root planning – 1 quadrant	\$55.00	\$182–\$414
Periodontal (gum) maintenance	\$35.00	\$107–\$243
Removal/extraction of erupted tooth	\$10.00	\$124–\$282
Removal/extraction of impacted tooth – completely bony	\$115.00	\$362–\$825
Crown – porcelain fused to high noble metal*	\$255.00	\$839–\$1,911
Implant supported retainer for porcelain fused to metal fixed partial denture*	\$555.00	\$1,079–\$2,458
Occlusal appliance, by report (for treatment of TMJ)	\$216.00	\$730–\$1,662

\*The co-payments for fixed and removable restorations (crowns, bridges, implant/abutment supported prosthetics, complete and partial dentures) do not include additional charges for material upgrades (such as gold/high noble metal or porcelain used in molar restorations), CAD/CAM services, complex rehabilitation or characterizations (for dentures). Any additional allowable charge for these upgrades is the patient's responsibility as specifically outlined in your Patient Charge Schedule (PCS). For questions regarding these charges you may contact Customer Service at 800.Cigna24 (800.244.6224). Please refer to your PCS for full details.

**Together, all the way.<sup>®</sup>**



**Offered by: Cigna Health and Life Insurance Company or its affiliates.**

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## Smile. You're covered.

You can save money on a wide range of services, including:

- › **Preventive care** – cleanings, fluoride, sealants, bitewing X-rays, full mouth X-rays and more
- › **Basic care** – tooth-colored fillings (called resin or composite) and silver-colored fillings (called amalgam)
- › **Major services** – crowns, bridges, dentures (including those placed over implants), root canals, oral surgery, extractions, treatment for periodontal (gum) disease, and more
- › **Orthodontic care** – braces for children and adults
- › **General anesthesia** – when medically necessary
- › **Teeth whitening** – using take-home bleaching trays and gel
- › **Temporomandibular joint (TMJ)** – diagnosis and treatment, including cone beam x-ray and appliance
- › **Athletic mouth guard** – including creation and adjustments

## More about your coverage

- › **No deductibles or waiting periods.** You don't have to reach an out-of-pocket cost before your insurance starts.
- › **No dollar maximums.** Your coverage isn't limited by a dollar amount.
- › **Network dentists file claims for you.** No paperwork for you.
- › **No age limit on sealants.** Helps prevent tooth decay.
- › **Cancer detection.** Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- › **24/7 access to dental information line.** Trained professionals can help answer your questions about dental treatment and clinical symptoms.
- › **Cigna Identity Theft Program.**<sup>3</sup> Help resolving critical identity theft issues.
- › **Cigna Dental Oral Health Integration Program®.** Enhanced dental coverage for customers with certain medical conditions who enroll in this program.

## Choosing a Dentist

- › You must choose a network general dentist to manage your overall care. You won't be covered if you go to a dentist who's not in our network.<sup>4</sup>
- › Each family member can choose their own dentist
- › Referrals are required for specialty care services, except for pediatric dentists for children under 13 and orthodontics.\*

## Finding a network dentist is easy.

Visit **Cigna.com** to find a network general dentist.

Call 800.Cigna24 (800.244.6224) to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email

\* Coverage for treatment by a pediatric dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services generally must be obtained from a network general dentist.

## Limitations

PROCEDURE	LIMIT
Oral evaluations	Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic oral evaluations (D0120), comprehensive oral evaluations (D0150), comprehensive periodontal evaluations (D0180), and oral evaluations for patients under 3 years of age (D0145)
X-rays (non-routine)	Full mouth: 1 every 3 calendar years Panorex: 1 every 3 calendar years
Periodontal root planing and scaling	Limit 4 quadrants per consecutive 12 months
Periodontal maintenance	Limited to 4 per year and (Only covered after active periodontal therapy)
Crowns and inlays	Replacement 1 every 5 years
Bridges	Replacement 1 every 5 years
Dentures and partials	Replacement 1 every 5 years
Orthodontic treatment	Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient
Relines, rebases	One every 36 months
Denture adjustments	Four within the first 6 months after installation
Prosthesis over implant	Replacement 1 every 5 years if unserviceable and cannot be repaired
TMJ treatment	One occlusal orthotic device per 24 months

## Limitations

PROCEDURE	LIMIT
Athletic mouth guard	One athletic mouth guard per 12 months
General anesthesia/IV sedation	General anesthesia is covered when performed by an oral surgeon when medically necessary for covered procedures listed on the PCS. IV sedation is covered when performed by a periodontist or oral surgeon when medically necessary for covered procedures listed on the PCS. Plan limitation for this benefit is 1 hour per appointment.

### Alternate Benefits

If more than one professionally accepted and appropriate method of treatment can be used to treat a dental condition, coverage will be limited to the less costly covered service. If you choose the more costly service, the copay listed on the PCS will not apply. Discuss your options and increased financial obligations with your dentist.

**Listed below are the services or expenses which are NOT covered under your Dental plan. You will be responsible for these services at the dentist's usual fees. There's no coverage for:**

- › Services for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- › Charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States government or by a state or municipal government if the person had no insurance
- › Services received to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- › Services for the charges which the person is not legally required to pay
- › Charges which would not have been made if the person had no insurance
- › Services received due to injuries which are intentionally self-inflicted
- › Services not listed on the PCS
- › Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in your plan documents)<sup>4</sup>
- › Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws
- › Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- › Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war<sup>5</sup>
- › Services performed primarily for cosmetic reasons unless specifically listed on your PCS
- › Consultations and/or evaluations associated with services that are not covered
- › Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis
- › General anesthesia, sedation and nitrous oxide, unless specifically listed on your PCS
- › General anesthesia or IV sedation when used for the purpose of anxiety control or patient management
- › Prescription medications
- › Procedures, appliances or restorations if the main purpose is to: a. change vertical dimension (degree of separation of the jaw when teeth are in contact); b. restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction
- › Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect
- › Any services related to surgical implants, including placement, repair, maintenance, removal, and implant abutment(s) unless specifically listed on your PCS
- › Services considered unnecessary or experimental in nature or do not meet commonly accepted dental standards
- › Procedures or appliances for minor tooth guidance or to control harmful habits
- › Services and supplies received from a hospital
- › Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.<sup>6</sup>
- › The completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage<sup>7</sup>
- › The completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your PCS<sup>7</sup>
- › Infection control and/or sterilization
- › The recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement

- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your PCS
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure
- Services performed by a prosthodontist
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy
- Any localized delivery of antimicrobial agent procedures when more than eight of these procedures are reported on the same date of service
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement
- Services to correct congenital malformations, including the replacement of congenitally missing teeth
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the PCS
- Crowns, bridges and/or implant supported prosthesis used solely for splinting
- Resin bonded retainers and associated pontics
- As to orthodontic treatment: incremental costs associated with optional/elective materials; orthognathic surgery appliances to guide minor tooth movement or correct harmful habits; and any services which are not typically included in orthodontic treatment.

If any law requires coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) does not apply.

**This document outlines the highlights of your plan. For a complete list of both covered and non-covered services, including benefits required by your state, see your official plan documents (the Group Contract and Plan Booklet/Combined Evidence of Coverage and Disclosure Form/Certificate of Coverage). If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.**



1. "Cigna Dental Care" is the brand name used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care (including Dental HMO) plans, and plans with open access features. Cigna Dental Care plans are not available in the following states: AK, HI, ME, MT, NH, NM, ND, PR, RI, SD, VI, VT, WV, and WY.
2. Costs listed for the Cigna Dental Care plan do not vary. Estimated costs without dental coverage may vary based on location and dentists' actual charges. These estimated costs are based on charges submitted to Cigna in 2015/2016 and are intended to reflect national average charges as of July 2018 assuming an annual cost increase of three percent. Estimates have been adjusted to reflect the 2016 Cigna Dental Care geographical membership distribution. Office visit fee may also apply.
3. **This is NOT insurance and does not provide for reimbursement of financial losses.** The Cigna Identity Theft Program is provided under a contract with Generali Global Assistance. Full terms, conditions and exclusions are contained in the client program description.
4. **Minnesota residents:** You must visit your selected network dentist in order for the charges on the PCS to apply. You may also visit other dentists that participate in our network or you may visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We will pay 50% of the value of your network benefit for those services. Of course, you'll pay less if you visit your selected Cigna Dental Care network dentist. Call Customer Services for more information.  
**Oklahoma residents:** Cigna Dental Care is an Employer Group Pre-Paid Dental Plan. You may also visit dentists outside the Cigna Dental Care network. If you do, the fees listed on the PCS will not apply. You will be responsible for the dentist's usual fee. We pay non-network dentists the same amount we'd pay network dentists for covered services. Of course, you'll pay less if you visit a network dentist in the Cigna Dental Care network. Call Customer Services for more information.
5. **Oklahoma residents:** This exclusion is replaced by the following: War or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
6. **Arizona and Pennsylvania residents:** This exclusion does not apply. **Kentucky and North Carolina residents:** Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. **Maryland residents:** Services compensated under group medical plans are not excluded.
7. **California and Texas residents:** Treatment for conditions already in progress on the effective date of your coverage are not excluded if otherwise covered under your PCS.

Dentists who participate in Cigna's network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Cigna Dental Care plans are insured by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636**, Florida Statutes, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc. (KY & IL), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are insured by Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc. Policy forms: OK - HP-POL115; TN - HP-POL134/HC-CER17V1 et al. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

- 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 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](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

Cigna  
Nondiscrimination Complaint Coordinator  
PO 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](mailto: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  
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, 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).



## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna 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, 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 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 LỜI Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, 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 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, 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, 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 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 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, 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 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 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 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-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 می‌شود. برای مشتریان فعلی Cigna، 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 ناشنوايان: شماره 711 را شماره‌گیری کنید).

**No Cost Language Services** for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-244-6224 for Cigna medical/dental or 1-866-421-8629 for Cigna Behavioral Health mental health/substance abuse. For more help, call either the HMO Help Center at 1-888-466-2219 or for Non-HMO plans (e.g. PPO) call the CA Dept. of Insurance at 1-800-927-4357. **English**

**Servicios de idioma sin costo** para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-244-6224 para servicios médicos/dentales de Cigna o al 1-866-421-8629 para servicios de salud mental/farmacodependencia de Cigna Behavioral Health. Para obtener ayuda adicional, llame al Centro de ayuda HMO al 1-888-466-2219 o para los planes que no sean HMO (p. ej. PPO) llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得**免費語言服務**。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與 Cigna 醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 Cigna Behavioral Health 精神健康 / 物質濫用。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電 1-800-927-4357 與加州保險部聯絡。 **Chinese**

**خدمات لغوية بدون تكلفة** للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأمين صادرة في ولاية كاليفورنيا. يمكنك الاستعانة بمترجم. يمكنك طلب قراءة الوثائق لك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-244-6224 لخدمات Cigna الطبية / صحة الأسنان أو على الرقم 1-866-421-8629 لخدمات Cigna للصحة السلوكية والنفسية / إساءة استخدام المواد المخدرة. للحصول على المزيد من المساعدة، اتصل إما بمركز HMO للمساعدة على الرقم 1-888-466-2219 أو للبرامج الأخرى غير HMO (مثل PPO)، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 **무료 언어 지원 서비스**. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 Cigna 의료/치과 안내번호(1-800-244-6224번), 혹은 Cigna Behavioral Health 정신 건강/약물 남용 안내번호(1-866-421-2219번)으로 연락해주시십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나비-HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주 보험국(CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 연락해주시십시오. **Korean**

**Walang Gastos na Mga Serbisyo sa Wika** para sa mga customer na nakatira sa California at mga customer na nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-244-6224 para sa medikal/dental ng Cigna o sa 1-866-421-8629 para sa kalusugang pangkaisipan/pag-abuso sa droga ng Cigna Behavioral Health. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

**Dịch vụ trợ giúp ngôn ngữ miễn phí** cho khách hàng sinh sống trong tiểu bang California và khách hàng sống ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi cho chương trình bảo hiểm y tế/nha khoa Cigna tại số 1-800-244-6224, hoặc gọi số 1-866-421-8629 cho chương trình chăm sóc sức khỏe tâm thần/lạm dụng chất gây nghiện thuộc Chương trình Sức khỏe Hành vi của Cigna. Để được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình PPO). **Vietnamese**

**សេវាបកប្រែភាសាដោយឥតគិតថ្លៃ** សំរាប់អតិថិជនដែលរស់នៅក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា និងអតិថិជនដែលរស់នៅក្រៅរដ្ឋកាលីហ្វ័រនីញ៉ា ដែលបានរ៉ាប់រង នៅក្រោមច្បាប់សន្យា បានចេញឱ្យក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឱ្យអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើលិខិត ID របស់អ្នក ឬលេខ 1-800-244-6224 សំរាប់ខាង សុខភាព/ធុញ Cigna ឬ 1-866-421-8629 សំរាប់ខាងគិរិយាបថ សុខភាពអារម្មណ៍/ការរំលោភសារធាតុញៀន Cigna។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយ HMO តាមលេខ 1-888-466-2219 ឬសំរាប់គំរាងមិនមែនជា HMO (ដូចជា PPO) ទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រង រដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ **Khmer**

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ** ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫੋਰਨੀਆ ਵਿੱਚ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫੋਰਨੀਆ ਤੋਂ ਬਾਹਰ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਕੈਲੀਫੋਰਨੀਆ ਵਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਲਿਸੀ ਦੇ ਅਧੀਨ ਕਵਰਡ ਹਨ। ਤੁਹਾਨੂੰ ਦੁਬਾਰੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਸਾਨੂੰ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਉੱਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਜਾਂ Cigna ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-244-6224 ਤੇ ਜਾਂ Cigna ਵਿਵਹਾਰਕ ਸਿਹਤ ਮਾਨਸਿਕ ਸਿਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਦੁਰਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਮਦਦ ਕੇਂਦਰ ਨੂੰ 1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾਵਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਮਾ ਵਿਭਾਗ (CA Dept. of Insurance) ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**



خدمات مجانی مربوط به زبان برای مشتریانی که در کالیفرنیا زندگی می کنند و مشتریانی که در خارج کالیفرنیا زندگی کرده و بر اساس بیمه نامه ای که در کالیفرنیا صادر شده تحت پوشش هستند. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگویند که مدارک به زبان شما برایتان قرآنت شوند و برخی از آنها به زبان شما برایتان ارسال شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا به شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی Cigna و یا به شماره 1-866-421-8629 برای برنامه بهداشت روانی/سوء استفاده از مواد مخدر طرح بهداشت رفتاری Cigna تلفن کنید. برای دریافت کمک بیشتر، به مرکز کمک HMO به شماره 1-866-466-2219 و یا برای طرح های غیر HMO (برای مثال PPO) به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. **Persian**

**無料の言語サービス。** カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まいで、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカードに記載の電話番号、またはCigna医療・歯科サービス担当：1-800-244-6224、またはCigna Behavioral Health（メンタルヘルス・薬物乱用）サービス担当：1-866-421-8629までご連絡ください。その他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。  
**Japanese**

**Бесплатные услуги перевода** для клиентов, проживающих на территории штата Калифорния, а также для тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши документы, а также выслать перевод некоторых из них на вашем языке. Для получения помощи, позвоните нам по телефону, указанному в вашей Идентификационной карте, по вопросам медицинского и стоматологического обслуживания, предоставляемого компанией Cigna, позвоните по телефону 1-800-244-6224, по вопросам связанным с психическим здоровьем/злоупотреблением алкоголем или наркотиками обращайтесь по телефону 1-866-421-8629 в программу Cigna Behavioral Health. Для получения дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

**Անվճար Լեզվապահ Ծառայություններ** անդամների համար, ովքեր բնակվում են Կալիֆոռնիայում և անդամների համար, ովքեր բնակվում են Կալիֆոռնիայից դուրս բայց ապահովագրված են Կալիֆոռնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ 1-800-244-6224, Cigna-ի բժշկական/առողջապահական ծրագրի համար կամ 1-866-421-8629 Cigna Վարվեցողական Առողջապահության հոգվեան առողջություն/թմրամիջոցների համար: Լրացուցիչ օգնության համար զանգահարեք կամ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով:  
**Armenian**


**Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi** rau cov qhua uas nyob hauv xeev California thiab cov qhua uas nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus. Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau Cigna chaw pab them nqi kho mob/kho hmiav los sis 1-866-421-8629 rau Cigna Chaw pab them nqi kho Kev Coj Cuj Pwm kev puas hwb/kev quav tshuaj yeeb dej caw. Yog xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Muab Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

कैलिफ़ोर्निया और कैलिफ़ोर्निया के बाहर रहने वाले कैलिफ़ोर्निया में जारी पॉलिसी के तहत कवर किये गए ग्राहकों के लिए **निःशुल्क भाषा सेवाएं**। आप एक दुआषिया प्राप्त कर सकते हैं। आप इन दस्तावेजों को किसी से पढ़वा सकते हैं और कुछ दस्तावेजों को अपनी भाषा में प्राप्त कर सकते हैं। Cigna स्वास्थ्य/दंत के लिए अपने ID कार्ड पर सूचीबद्ध नंबर 1-800-244-6224 पर या Cigna व्यवहार स्वास्थ्य मानसिक स्वास्थ्य/नशे की अधिकता की सहायता के लिए, 1-866-421-8629 पर कॉल करें। अधिक सहायता के लिए, HMO सहायता केंद्र पर 1-888-466-2219 पर कॉल करें या गैर-HMO योजनाओं (उदा. PPO) के लिए 1-800-927-4357 पर CA बीमा विभाग (CA Dept. of Insurance) को कॉल करें। **Hindi**

**บริการภาษาโดยไม่เสียค่าใช้จ่าย** สำหรับลูกค้าที่อาศัยอยู่ในรัฐแคลิฟอร์เนีย และที่อาศัยอยู่นอกรัฐแคลิฟอร์เนียที่ได้รับการคุ้มครองภายใต้กรมธรรม์ที่ออกในรัฐแคลิฟอร์เนีย คุณสามารถขออ่านเอกสารได้ คุณสามารถขอให้อ่านเอกสารให้คุณฟัง และขอให้ส่งเอกสารบางส่วนถึงคุณเป็นภาษาของคุณ หากต้องการความช่วยเหลือ โปรดโทรศัพท์ถึงเราตามหมายเลขที่ระบุไว้บนบัตรประจำตัวของคุณ หรือหมายเลข 1-800-244-6224 สำหรับบริการของ Cigna ด้านการรักษายาสูบ/ทันตกรรมของ Cigna หรือ 1-866-421-8629 สำหรับบริการของ Cigna Behavioral Health ด้านสุขภาพจิต/การใช้สารที่มีผลต่อจิตประสาทในทางที่ผิด หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือสำหรับแผนการรักษายาสูบแบบ HMO ที่หมายเลข 1-888-466-2219 หรือสำหรับแผนการรักษายาสูบที่ไม่ใช่ HMO (เช่น PPO) โปรดโทรศัพท์ถึง Dept. of Insurance ของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 **Thai**

2020

Summary of Benefits and Coverage:  
What this Plan Covers & What You Pay  
For Covered Services

 All <b>copayment</b> and <b>coinsurance</b> costs shown in this chart are after your <b>deductible</b> has been met, if a <b>deductible</b> 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	None
	<a href="#">Specialist</a> visit	Not covered	Not covered	See mental/behavioral health and substance abuse disorder section
	<a href="#">Preventive care/ screening/ immunization</a>	Not covered	Not covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not covered	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Not covered	Not covered	
	Preferred brand drugs (Tier 2)	Not covered	Not covered	None
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not covered	Not covered	None
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	None
	<a href="#">Urgent care</a>	Not covered	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/STC - Short Term Counseling; Not covered/Other Services	Not covered	Coverage is limited to annual max of: 5 visits per issue
	Inpatient services	Not covered	Not covered	None
	Office visits	Not covered	Not covered	
If you are pregnant	Childbirth/delivery professional services	Not covered	Not covered	None
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not covered	Not covered	None
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	None
	<a href="#">Habitatation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	None
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	None
	<a href="#">Hospice services</a>	Not covered	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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic Care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Emergency medical transportation</li> <li>• Emergency room services</li> <li>• Eye care (Children)</li> <li>• Facility Fees</li> <li>• Habilitation services</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Home Health Care</li> <li>• Hospice services</li> <li>• Infertility treatment</li> <li>• Laboratory Services</li> <li>• Long-term care</li> <li>• Mental/Behavioral health inpatient and outpatient services</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Other practitioner office visit</li> <li>• Physician/surgeon fees</li> <li>• Prescription drugs</li> <li>• Prenatal/postnatal/delivery inpatient services for pregnancy</li> </ul> | <ul style="list-style-type: none"> <li>• Primary care services</li> <li>• Private-duty nursing</li> <li>• Radiological services</li> <li>• Rehabilitation services</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Skilled nursing</li> <li>• Specialist services</li> <li>• Substance use disorder inpatient and outpatient services</li> <li>• Urgent 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 [plan](#) document.)**

- Short Term Counseling (5 visits; per issue)

### **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](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](http://www.HealthCare.gov), 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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions 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](http://www.dol.gov/ebsa/healthreform) or the California Department of Insurance at 1-800-927-4357. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: California Department of Managed Health Care Help Center at 888-466-2219. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov).

### **Does this plan provide Minimum Essential Coverage? No**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet the Minimum Value Standards? No**

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, kwijigo 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](#) N/A
- [Specialist copayment](#) N/A
- [Hospital \(facility\) coinsurance](#) N/A
- [Other coinsurance](#) N/A

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

#### In this example, Peg would pay:

This condition is Not covered, so patient pays 100%.

Cost Sharing	
Deductibles*	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	\$12,800
<b>The total Peg would pay is</b>	<b>\$12,800</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's overall deductible](#) N/A
- [Specialist copayment](#) N/A
- [Hospital \(facility\) coinsurance](#) N/A
- [Other coinsurance](#) N/A

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

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

This condition is Not covered, so patient pays 100%.

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	\$7,400
<b>The total Joe would pay is</b>	<b>\$7,400</b>

### Mia's Simple Fracture

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

- The [plan's overall deductible](#) N/A
- [Specialist copayment](#) N/A
- [Hospital \(facility\) coinsurance](#) N/A
- [Other coinsurance](#) N/A

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

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

This condition is Not covered, so patient pays 100%.

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	\$1,900
<b>The total Mia would pay is</b>	<b>\$1,900</b>

Plan Name: City of Richmond Short Term Counseling



 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 <a href="http://www.mycigna.com">www.mycigna.com</a> . For general definitions of common terms, such as <a href="#">allowed amount</a> , <a href="#">balance billing</a> , <a href="#">coinsurance</a> , <a href="#">copayment</a> , <a href="#">deductible</a> , <a href="#">provider</a> , or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 1-877-622-4327 to request a copy.		
Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the out-of-pocket limit for this plan?	This plan has no <a href="#">out-of-pocket limit</a> .	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a network provider?	Yes. See <a href="http://www.mycigna.com">www.mycigna.com</a> or call 1-877-622-4327 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> .
Do you need a referral to see a specialist?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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