The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $500/individual or $1,000/family For out-of-network providers: $500/individual or $1,000/family Combined medical/behavioral deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, prescription drugs, emergency room visits, urgent care facility visits, in-network hospice, in-network Durable medical equipment.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
What is the out-of-pocket		

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply	20% coinsurance	No Charge for initial visit per Calendar Year.
	Specialist visit	$20 copay/visit Deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	The lesser of 50% or $500 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail &		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail 30 days), $40 copay/prescription (retail & home delivery 90 days) Deductible does not apply		

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** No charge/all other services **Deductible does not apply	20% coinsurance/office visit 20% coinsurance/all other services	The lesser of 50% or $500 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses. No Charge for initial visit per Calendar Year; subsequent visits at no more than PCP cost share.
	Inpatient services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$20 copay/PCP visit** $20 copay/ Specialist visit** **Deductible does not apply	20% coinsurance/PCP visit 20% coinsurance/ Specialist visit	The lesser of 50% or $500 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	No charge	20% coinsurance	The lesser of 50% or $500 penalty for no out-of-network precertification. Coverage is limited to 150 days annual max.
	Durable medical equipment	No charge Deductible does not apply	20% coinsurance	The lesser of 50% or $500 penalty for no out-of-network precertification.
	Hospice services	No charge/inpatient services** No charge/outpatient services** **Deductible does not apply	20% coinsurance/inpatient services 20% coinsurance/outpatient services	The lesser of 50% or $500 penalty for no out-of-network precertification.
	Children's eye exam	No charge Deductible does not apply	No charge Deductible does not apply	Coverage is limited to one exam
	Children's glasses	Not covered		

Your Rights to Continue Coverage:

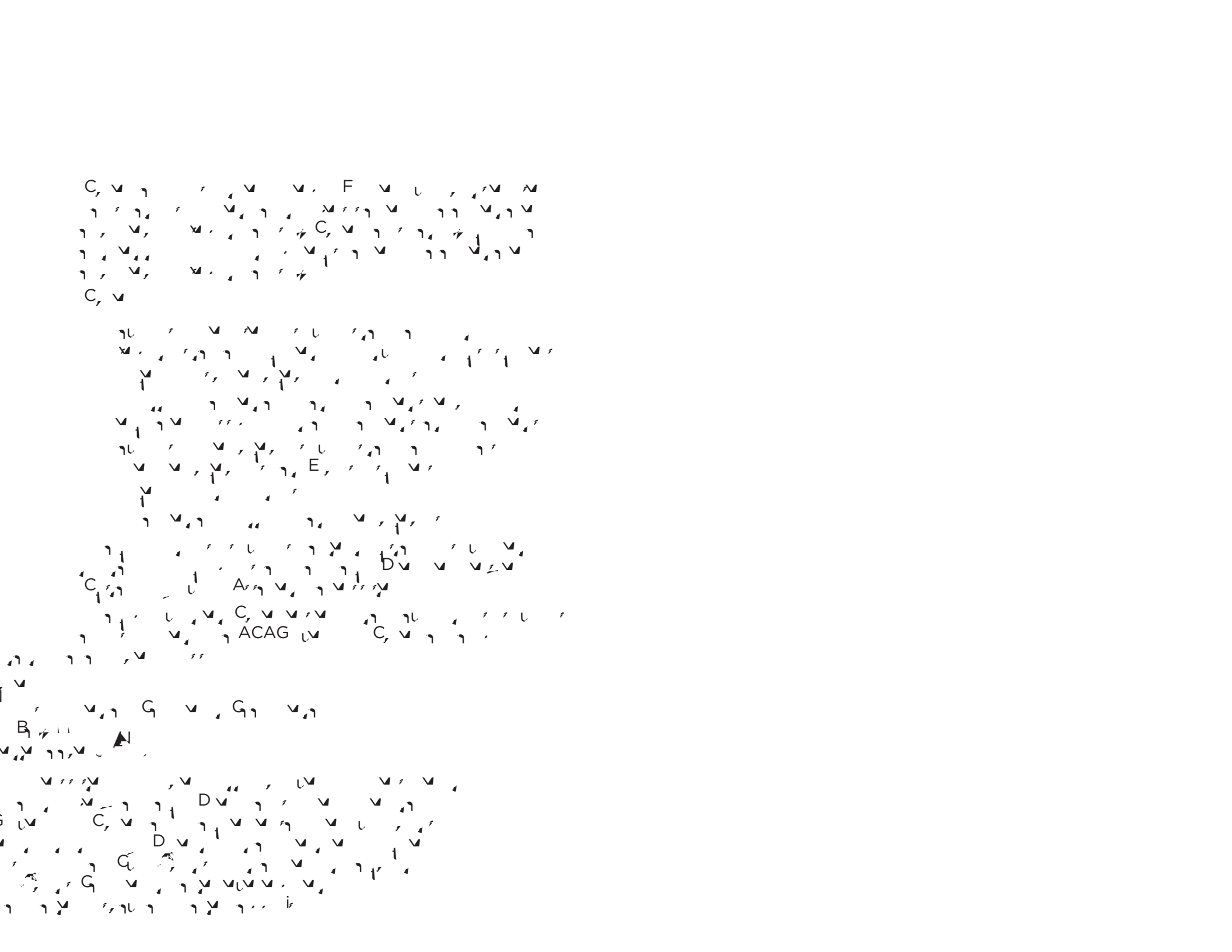
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Bureau of Insurance at 1-800-300-5000 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal

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.



Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of
are available to you. For current Cigna customers:
call th number on the back of
1.800.2 (TTY: 711)

Spanish – ATENC
sin cargo, a su
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
的現有客戶，請致電您的 ID
1.8

Vie
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:
무료로 이용하실 수 있습니다. 현재 Cigna 가입자임을
카드 뒷면에 있는
1.800.244.6224 (TTY: 다이얼 71

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

Russian – В
услуги перево
позвоните по номеру, указанному на обратной стороне
вашей идентификационной карточки участника плана.
Если
планов,

Arabic
الحاليين يرجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب
(711 اتصل ب :TTY) 1.800.244.6224.

French Creole ATANSYON: Gen sèvis èd pou lang ki disponib gratis
pou ou. Pou kliyan Cigna yo,
Fre
veuillez appeler le numéro indiqué au verso de votre carte d'identit
Sinon, veuillez appeler le numéro 1.800
num 5 711).

Portuguese – ATENÇÃO: Tem ao
lingu
número que se encontra no verso do seu cartão de ident
contrário, ligue pa

Polish
języ
na odw
skorzystanie z numeru 1.800.244.6224
skorzystania z dostępnej, bezpłatnej pomocy
kowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany
ie karty identyfikacyjnej. Wszystkie inne osob
7 (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
用いただけます。現在のCignaのお客様は、ID
ご連絡ください。その他の方は、1.800.244.6224
まで、お電話

Italian – ATTENZIONE: Sono disponibili servizi di assistenza li
gratu
tessera di identificazione. In caso contrario, chiamare il numero
1.800.244.6224 (utenti TTY: chiamare il numero 711).

Cigna-Kunde sind, rufen Sie bitte
Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an
(TTY: Wählen Sie 711).

Farsi (Persian)
Cigna
1.800.244.6224 (شماره تلفن ویژه ناشنوایان: شماره 711 را
شماره دیگری کنید).