This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.myCigna.com** or by calling 1-800-Cigna24. The Uniform glossary can be obtained at www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$500** person/**$1,500** family. Out-of-network providers: **$500** person/**$1,500** family. Not applicable to in-network preventive care, Rx drugs	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet these **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For network providers **$15,000** person **/ $45,000** family; For out-of-network providers **$20,000** person / **$60,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, co-payments, plan deductibles, balance-billed charges, penalties for no pre-authorization, uncovered care	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-Cigna24.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for information about **excluded services**.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	30% co-insurance	40% co-insurance	--------------- none --------------------
	Specialist visit	30% co-insurance	40% co-insurance	--------------- none --------------------
	Other practitioner office visit	30% co-insurance	40% co-insurance	Chiropractic coverage is limited 12 annual visits.
	Preventive care/screening/immunization	No charge	40% co-insurance	--------------- none --------------------
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	40% co-insurance	--------------- none --------------------
	Imaging (CT/PET scans, MRIs)	30% co-insurance	40% co-insurance	--------------- none --------------------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com.	Generic drugs	25% co-insurance/prescription (retail). 25% co-insurance (home delivery)	Not covered	Coverage is limited to a 90 day supply (retail) and limited to a 90 day supply (home delivery); Specialty prescriptions are limited to a 30 day supply, with 1 refill of a specialty medication at retail
	Preferred brand drugs	25% co-insurance/prescription (retail). 25% co-insurance (home delivery)	Not covered	Coverage is limited to a 90 day supply (retail) and limited to a 90 day supply (home delivery); Specialty prescriptions are limited to a 30 day supply, with 1 refill of a specialty medication at retail
	Non-preferred brand drugs	25% co-insurance/prescription (retail). 25% co-insurance (home delivery)	Not covered	Coverage is limited to a 90 day supply (retail) and limited to a 90 day supply (home delivery); limited to a 30 day supply, with 1 refill of a specialty medication at retail
	Specialty drugs	25% co-insurance/prescription (retail). 25% co-insurance (home delivery)	Not covered	Coverage is limited to a 30 day supply, with 1 refill of a specialty medication at retail
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	40% co-insurance	--------------- none ---------------
	Physician/surgeon fees	30% co-insurance	40% co-insurance	--------------- none ---------------
If you need immediate medical attention	Emergency room services	30% co-insurance	30% co-insurance	--------------- none ---------------
	Emergency medical transportation	30% co-insurance	30% co-insurance	--------------- none ---------------
	Urgent care	30% co-insurance	30% co-insurance	--------------- none ---------------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	40% co-insurance	--------------- none ---------------
	Physician/surgeon fee	30% co-insurance	40% co-insurance	--------------- none ---------------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	--------------- none --------------------
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	--------------- none --------------------
	Substance use disorder outpatient services	Not Covered	Not Covered	--------------- none --------------------
	Substance use disorder inpatient services	Not Covered	Not Covered	--------------- none --------------------
If you are pregnant	Prenatal and postnatal care	30% co-insurance	40% co-insurance	--------------- none --------------------
	Delivery and all inpatient services	30% co-insurance	40% co-insurance	--------------- none --------------------
If you need help recovering or have other special health needs	Home health care	30% co-insurance	40% co-insurance	--------------- none --------------------
	Rehabilitation services	30% co-insurance	40% co-insurance	Coverage for Rehabilitation services is limited to 60 days/visits annually. Cardiac Rehabilitation services are limited to 36 days/visits annually.
	Habilitation services	Not Covered	Not Covered	--------------- none --------------------
	Skilled nursing care	30% co-insurance	40% co-insurance	Coverage is limited to 60 days annual max
	Durable medical equipment	30% co-insurance	40% co-insurance	--------------- none --------------------
	Hospice service	30% co-insurance	40% co-insurance	--------------- none --------------------
If your child needs dental or eye care	Eye exam	No charge for exam	Not Covered	One eye exam every 12 months
	Glasses	$10 co-pay for frames and lenses.	Not covered	One pair of glasses every 24 months; frames allowance of $75 (with 20% discount on balance over $75); no limit on frames for dependents under age 18
	Dental check-up	Not Covered	Not Covered	--------------- none --------------------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (**This isn't a complete list. Check your policy or plan document for other excluded services.**)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult)
- Dental Care (Child)
- Habilitation services
- Hearing aid
- Infertility treatment
- Long-term care
- Mental/Behavioral health inpatient or outpatient
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Prescription drugs used to treat a Mental Health or Substance Use Disorder
- Routine foot care
- Substance use disorder inpatient and outpatient services
- Weight loss programs

Other Covered Services (**This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.**)

- Chiropractic care – limited
- Routine eye care – limited

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may apply.

For more information on your rights to continue coverage, contact the plan at 1-800-832-7113 or 1-513-381-6886. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. 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. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-686-1526 or visit http://www.insurance.ohio.gov/Pages.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,600
- **Patient pays** $2,940

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1000
Copays	$0
Coinsurance	$1,940
Limits or exclusions	$0
Total	**$2,940**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,605
- **Patient pays** $1,795

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance $	$1,295
Limits or exclusions	$0
Total	**$1,795**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.