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?	$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?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $5,500/individual or $11,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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.

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	$25 copay/office visit No charge/MDLIVE visit	Not covered	No charge for office visits with an in-network physician that is a member of the RWJBarnabas Health Medical Group
	Specialist visit	$50 copay/office visit No charge/MDLIVE visit	Not covered	
	Preventive care/ screening/ immunization	No charge	Not covered	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	$250 copay per type of scan/day	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at express-scripts.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail & home delivery 90 days)	Not covered	**Specialty medications** must be filled through Express Scripts and the SaveOn Program. **SaveOn** Members filling Specialty Rx for the first time will be asked to enroll in the SaveOn program. Members that enroll and have eligible specialty medications will receive their medications for a $0 copay. Your Medications must be on the SaveOn Drug List in order to be covered at No Charge.
	Preferred brand drugs (Tier 2)	$60 copay/prescription (retail 30 days), $150 copay/prescription (retail & home delivery 90 days	Not covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $188 copay/prescription (retail & home delivery 90 days)	Not covered	
	Specialty drugs (Tier 4)	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 copay/visit	Not covered	Not covered
	Physician/surgeon fees	No charge	Not covered	Per visit copay is waived for non-surgical procedures.
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	None
	Emergency medical transportation	No charge	No charge	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Urgent care	$50 copay/visit	Not covered	Out-of-network air ambulance services are paid at the in-network cost share. Services for MH/SA diagnoses will be payable according to Emergency room care benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,000 copay/admission	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/office visit; No charge/all other services	Not covered	None
	Inpatient services	$3,000 copay/admission	Not covered	Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	Not covered	Includes medical services for MH/SA diagnoses.
	Childbirth/delivery professional services	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.

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)	
	Childbirth/delivery facility services	$3,000 copay/admission	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$25 copay/PCP visit $50 copay/ Specialist visit $50 copay/ Specialist visit for chiropractic care	Not covered	Coverage is limited to annual max of: 20 days for Pulmonary rehab and Cognitive therapy services; 30 days per therapy type for Physical, Speech & Occupational therapies; 36 days for Cardiac rehab services; 25 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$25 copay/PCP visit $50 copay/ Specialist visit	Not covered	Not covered
	Skilled nursing care	No charge	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Durable medical equipment	No charge	Not covered	Coverage is limited to 100 days annual max.
	Hospice services	No charge/inpatient services No charge/outpatient services	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye care (Children)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (25 days)
- Hearing aids (2 devices per 24 months)
- Infertility treatment (Lifetime max $5,000)
- Private-duty nursing (30 days)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: New Jersey Department of Banking and Insurance at (800) 446-7467.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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	$0
Specialist copay	$50
Hospital (facility) copay	$3,000
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$3,250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$3,270

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist coinsurance	$50
Hospital (facility) copay	$3,000
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$340

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copay	$50
Hospital (facility) copay	$3,000
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)* **6 Visits**

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Simple Copay Plan **Ben Ver:** 33 **Plan ID:** 38024311

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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

cigna healthcare

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

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

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

U.S. Department of Health and Human Services

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

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

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Proficiency of Language Assistance Services

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

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, !lame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - i±□: ft{rraJf,Sf□:9e.JftJHJ:t□!t□ia.l=l}Jij□f£ ◦ It□ Cigna Healthcare EfJJJi□□P , □rlfi&fflf□Efl ID -t1r®Ef1□□ ◦ □{-tg□¥ 1.800.244.6224 C □lr!H!H,i : □ffti 711) ◦

Vietnamese - XIN LU'U Y: Quy vi dU'Q'C c□p djch v1,1 trQ' giup v□ ng6n ngQ> mien phi. Danh cha khach hang hi(m tc;1i cua Cigna Healthcare, vui long goi s6 a mc;it sau the Hoi vien. Cac tmcmg hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

Korean - -?□I: □J□Oj □ J..□-§-o□J..l:= □□. <2! Oj 7'1 □ J..i 1:11 A□ 1f-E£ Ol-§-o□□ "? □□LIq_ □XH Cigna Healthcare 7□'fl 7'□ 'a□7JllJ..i := ID 7'□□ □121011 □:= □2□te:!.2.£ '2:!□oH-?□J..12.. 7IE□ q□ □□011:= 1.800.244.6224 (TTY: qo1□ 711)te:! ^{O}£ □2□0H-?□J..l2..

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. 0 kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian - BHv1MAHv1E: BaM MoryT npeAOCTaBt,1Tb 6ecnnaTHble ycnyrn nepeBOAa. Ecm1 Bbl y)f{e y4acTByeTe B nnaHe Cigna Healthcare, no3BOHll1Te no HOMepy, yKa3aHHOMY Ha o6paTHO□ CTOpOHe Bawe□ 111A8HTll1q:>111Kal...\1110HHO□ KapTO4Kll1 y4aCTHll1Ka nnaHa. Ecn111 Bbl He f!BmleTeCb y4aCTHIIIKOM OAHOro 1113 HaWIIIX nnaHOB, no3BOHll1Te no HOMepy 1.800.244.6224 (TTY: 711).

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French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS : composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servi<;:os de assistencia lingufstica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identifica<;:ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost□pnej, bezpfatnej pomocy j□zykowej, obecni klienci firmy Cigna Healthcare mog9 dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 51□$:I:.W : 87$:iR7;£-it□n□□-g-, □*{O)□iRsz::titt-!::'A7;£-c'f1JffII,'tctdt*9。 IJH'IO)Cigna HealthcareO)S□□J□;;t:_ ID:b- t-:'□ jijO)□it:ffl:□*c\ s□it,LZc'Ji□(tc.□I,'。 f-O){{Q0)7J□i, 1.800.244.6224 (TTY: 711) *c\ s□it,LZc'Ji□(tc.□I,'。

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

German - ACHTUNG: Die Leistungen der Sprachunterstotzung stehen Ihnen kostenlos zur Verfugung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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