



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 : \$3,000/individual - employee only or \$6,000/family maximum For out-of-network providers : \$3,000/individual - employee only or \$6,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan .	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. In-network preventive care & immunizations.	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/ .
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 : \$6,000/individual - employee only or \$12,000/family maximum (no more than \$6,000 per individual - within a family) For out-of-network providers : \$10,000/individual - employee only or \$20,000/family maximum (no more than \$10,000 per individual - within a 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 the out-of-pocket limit for this plan ?	Penalties for failure to obtain pre-authorization for services, 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 .

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	30% coinsurance /office visit; No charge/MDLIVE visit	50% coinsurance	No charge for office visits with an in-network physician that is a member of the RWJBarnabas Health Medical Group.
	Specialist visit	30% coinsurance /office visit No charge/MDLIVE visit	50% coinsurance	
	Preventive care/ screening/ immunization	No charge Deductible does not apply	50% 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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	30% coinsurance	Not covered	Specialty medications must be filled through Express Scripts and the SaveOn Program.
	Preferred brand drugs (Tier 2)	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)	
More information about prescription drug coverage is available at www.cigna.com	Non-preferred brand drugs (Tier 3)	30% coinsurance	Not covered	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 after deductible . Your Medications must be on the SaveOn Drug List in order to be covered at No charge.
	Specialty drugs (Tier 4)	30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out-of-network services are paid at the in-network cost share and deductible .
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible .
	Urgent care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	\$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	\$750 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance /office visit 30% coinsurance /all other services	50% coinsurance /office visit 50% coinsurance /all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	30% coinsurance	50% coinsurance	\$750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	In-Network Provider (You will pay the least)	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	<p>Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.</p> <p>Cost sharing does not apply for preventive services.</p> <p>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).</p>
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	<p>\$750 penalty for no out-of-network precertification.</p> <p>Coverage is limited to 100 days annual max.</p> <p>16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)</p>
	Rehabilitation services	30% coinsurance / visit	50% coinsurance / visit	<p>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.</p> <p>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	In-Network Provider (You will pay the least)	
	Habilitation services	30% coinsurance / visit	50% coinsurance / visit	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.
	Skilled nursing care	30% coinsurance	50% coinsurance	\$750 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	30% coinsurance	50% coinsurance	\$750 penalty for no out-of-network precertification.
	Hospice services	30% coinsurance /inpatient services 30% coinsurance /outpatient services	50% coinsurance /inpatient services 50% coinsurance /outpatient services	\$750 penalty for no out-of-network precertification.
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"> • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Eye care (Children) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric Surgery | <ul style="list-style-type: none">• Chiropractic care (25 days)• Hearing aids (2 devices per 24 months) | <ul style="list-style-type: none">• 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, 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	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$2,900
What isn't covered	
Limits or exclusions	\$30
The total Peg would pay is	\$5,930

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,140
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$5,440

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,790
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$2,800

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

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

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

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



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

Cigna Healthcare

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

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

U.S. Department of Health and Human Services

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

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

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Proficiency of Language Assistance Services

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

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, llame 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 - It Cigna Healthcare EfJJJi P , ID -t1rEf1 . 1.800.244.6224 C IrIH,i : fti 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 (l mc;it sau the Hoi vien. Cac tmcng hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

Korean - J J J. -s-o J. = . <2! Oj 7'1 J.i 1:11 A 1f-E OI-s-o " ? LIq_ XH Cigna Healthcare 7'fl 7' 'a 7JllJ.i := ID 7' 121011 : 2te!:2.E '2: !oH-? J..12.. 7IE q 0011:= 1.800.244.6224 (TTY: qo1 711)te: ! ° 20H-? J..12..

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

Russian - BHv1MAHv1E: BaM MoryT npeAOCTaBt,1Tb 6ecnnaTHble ycnynr 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 flBmleTeCb y4aCTHll1KOM OAHOpO 1113 HaWllIX nnaHOB, no3BOHll1Te no HOMepy 1.800.244.6224 (TTY: 711).

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(711 '-,I I :TTY) 1.800.244.6224 '-:I I .Jl

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 mogg 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\$:l:W : 87\$:iR7;£-it n -g-, {O} iRs::titt-!:'A7;£-c'f1Jffll,'tctdt*9。 IJH'IO)Cigna HealthcareO)S J ;t: ID:b- t- : ' jijO) it: ffl: *c\ s it,LZc'Ji (tc. ,'. f-O){(QO)7J i, 1.800.244.6224 (TTY: 711) *c\ s it,LZc'Ji (tc. ,'. ,'

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 Verfung. 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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