### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**

For **in-network providers**: $400/individual or $800/family  
For **out-of-network providers**: $1,200/individual or $2,400/family  

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 services covered before you meet your deductible?**

Yes. In-network **preventive care** & immunizations, office visits, emergency room visits, **urgent care** facility visits.

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/](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**: $2,650/individual or $5,300/family  
For **out-of-network providers**: $7,950/individual or $15,900/family  

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?**

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

### Will you pay less if you use a network provider?
Yes. See [www.myCigna.com](http://www.myCigna.com) or call 1-800-Cigna24 for a list of network providers.

**Why This Matters:**
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.

**Why This Matters:**
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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit $Deductible does not apply</td>
<td>35% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$40 copay/visit $Deductible does not apply</td>
<td>35% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Preventive care/ screening/ immunization <strong>Deductible does not apply</strong></td>
<td>No charge/visit** No charge/screening** No charge/immunizations**</td>
<td>Not covered/visit 35% coinsurance/screening Not covered/immunizations</td>
<td>None None None You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Contact your employer for non-Cigna coverage that may be available.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Contact your employer for non-Cigna coverage that may be available.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Contact your employer for non-Cigna coverage that may be available.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (Tier 4)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Contact your employer for non-Cigna coverage that may be available.</td>
</tr>
<tr>
<td></td>
<td>More information about prescription drug coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>contact Caremark at 1-877-347-7444</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$125 copay/visit Deductible does not apply</td>
<td>$125 copay/visit Deductible does not apply</td>
<td>Per visit copay is waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 copay/visit Deductible does not apply</td>
<td>$40 copay/visit Deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>15% coinsurance/all other services Do not apply</td>
<td>35% coinsurance/all other services Do not apply</td>
<td>50% penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification. 16 hour maximum per day</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/PCP visit**</td>
<td>35% coinsurance/PCP visit</td>
<td>50% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 30 days for pulmonary rehab, Physical, Occupational and Cognitive therapies; 36 days for Cardiac rehab services; 25 days annual max for Chiropractic care services; 30 days for Speech Therapy Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 copay/Specialist visit** **Deductible does not apply</td>
<td>35% coinsurance/Specialist visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification. Coverage is limited to 100 days annual max.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>50% penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>15% coinsurance/inpatient; 15% coinsurance/outpatient services</td>
<td>35% coinsurance/inpatient; 35% coinsurance/outpatient services</td>
<td>50% penalty for failure to precertify inpatient hospice services.</td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### 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.):**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- 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.)

- Chiropractic care (25 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: 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 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Pennsylvania Consumer Assistance Program at 877-881-6388. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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 a'tohwol ninisingo, kwijjigo 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**: $400
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $30
- The total Peg would pay is: $2,250

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

---

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

- **The plan's overall deductible**: $400
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$130</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $6,200
- The total Joe would pay is: $6,530

---

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

- **The plan's overall deductible**: $400
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 15%
- **Other coinsurance**: 15%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$30</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $630

---

**Plan Name:** HRA Zero Funding  **Ben Ver:** 12  **Plan ID:** 7476144
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 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. 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)

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）。


Russian – ВНИМАНИЕ: Вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной картки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: I-dial 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).


Persian (Farsi) - توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوا: شماره 711 را شمارهگیری کنید).