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: **$1,500**/individual or **$3,000**/family 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 & preventive medications are covered before you meet your deductible.	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 **$3,000**/individual or **$6,000**/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, the overall family out-of-pocket limit must be 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.myCigna.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.

Important Questions	Answers	Why This Matters:
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% coinsurance/visit	Not covered	None
	Specialist visit	20% coinsurance/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/visit** No charge/screening** No charge/immunizations** No charge/immunizations** **Deductible does not apply	Not covered	Coverage birth through age 12 Coverage age 13 and older None Coverage birth through age 12 Coverage age 13 and older 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail); $30 copay/prescription (home delivery)	Not covered	Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. Generic preventive medications are covered at no cost share.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail); $60 copay/prescription (home delivery)	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail); $100 copay/prescription (home delivery)	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)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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).
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% 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 need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 60 days annual max. 16 hour maximum per day
	Rehabilitation services	20% coinsurance/PCP visit 20% coinsurance/Specialist visit	Not covered	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (combined with Rehabilitation Services)
- Hearing aids (2 (one per ear) devices per 36 months, through age 17)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 or the Colorado Division of Insurance at 1-800-930-3745.

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 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	**$1,500**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,010**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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:

Cost Sharing	
Deductibles	$1,500
Copayments	$900
Coinsurance	$90
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,690**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,590**

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

Plan Name: Choice Fund Health Savings Account OAPIN **Ben Ver:** 8 **Plan ID:** 5828925 HP-POL/HP-APP 9/23/12

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Littleton Public Schools
Choice Fund Open Access Plus IN HSA Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Coinsurance	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable
Contract Year Deductible	Individual: $1,500 Family: $3,000

- Plan deductible always applies before any copay or coinsurance.
- All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.
- Home delivery drugs are not subject to the plan deductible.
- Prescription medications used to prevent any of the following medical conditions are not subject to the individual and/or family plan deductible: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency .

Note: Services where plan deductible applies are noted with a caret (^)

Contract Year Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000

- Plan deductible contributes towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

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Benefit	In-Network
Physician Services	
Physician Office Visit – Primary Care Physician (PCP) • All services including Lab & X-ray	After the plan deductible is met, your plan pays 80%
Physician Office Visit – Specialist • All services including Lab & X-ray	After the plan deductible is met, your plan pays 80%
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist)	
Surgery Performed in Physician's Office - PCP	After the plan deductible is met, your plan pays 80%
Surgery Performed in Physician's Office – Specialist	After the plan deductible is met, your plan pays 80%
Allergy Treatment/Injections Performed in Physician's Office PCP	After the plan deductible is met, your plan pays 80%
Allergy Treatment/Injections Performed in Specialist Office	After the plan deductible is met, your plan pays 80%
Allergy Serum - PCP	After the plan deductible is met, your plan pays 80%
Allergy Serum - Specialist	After the plan deductible is met, your plan pays 80%
• Dispensed by the physician in the office	
Cigna Telehealth Connection services	After the plan deductible is met, your plan pays 80%
• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com). • Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.	
Preventive Care	
Preventive Care Birth through age 12	Plan pays 100%
Ages 13 and older	Plan pays 100%
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.	
Immunizations Birth through age 12	Plan pays 100%
Ages 13 and older	Plan pays 100%

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Benefit	In-Network
Mammogram, PAP, and PSA Tests	Plan pays 100%
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	
Inpatient	
Inpatient Hospital Facility	After the plan deductible is met, your plan pays 80%
Semi-Private Room: Limited to the semi-private negotiated rate **Private Room:** Limited to the semi-private negotiated rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to the negotiated rate	
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 80%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 80%
Outpatient	
Outpatient Facility Services	After the plan deductible is met, your plan pays 80%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation - PCP	After the plan deductible is met, your plan pays 80%
Short-Term Rehabilitation – Specialist	After the plan deductible is met, your plan pays 80%
Contract Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – 60 days • Cardiac Rehabilitation – 36 days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • 60 days maximum per Contract Year • 16 hour maximum per day	After the plan deductible is met, your plan pays 80%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Contract Year	After the plan deductible is met, your plan pays 80%
Durable Medical Equipment • Unlimited maximum per Contract Year	After the plan deductible is met, your plan pays 80%

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Benefit	In-Network
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%
External Prosthetic Appliances (EPA) • Unlimited maximum per Contract Year	After the plan deductible is met, your plan pays 80%
Routine Foot Disorders	Not Covered
Hearing Aid • Maximum of 2 devices (one per ear) per 36 months • Includes testing and fitting of hearing aid devices. • Coverage through age 17	After the plan deductible is met, your plan pays 80%
Varicose Vein Treatment • Unlimited per contract year	After the plan deductible is met, your plan pays 80%
Medical Specialty Drugs	
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 80%
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 80%
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, your plan pays 80%
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges.	After the plan deductible is met, your plan pays 80%

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Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	In-Network	In-Network	In-Network
Laboratory	Plan pays 80%^	Plan pays 80%^	Plan pays 80%^	Plan pays 80%^
Radiology	Plan pays 80%^	Not Applicable	Plan pays 80%^	Plan pays 80%^
Advanced Radiology Imaging	Plan pays 80%^	Not Applicable	Plan pays 80%^	Plan pays 80%^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
	In-Network	In-Network	In-Network
Emergency Care	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^
Urgent Care	Plan pays 80% ^	Plan pays 80% ^	Not Applicable*

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	In-Network	In-Network
Hospice	Plan pays 80% ^	Plan pays 80% ^
Bereavement Counseling	Plan pays 80% ^	Plan pays 80% ^

Note: Services provided as part of Hospice Care Program
Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	In-Network	In-Network	In-Network	In-Network
Maternity	Plan pays 80%^	Plan pays 80% ^	Plan pays 80%^	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
Abortion (Non-elective procedures)	Plan pays 80%^	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^

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Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
Family Planning - Men's Services	Plan pays 80%^	Plan pays 80%^	Plan pays 80%^	Plan pays 80%^	Plan pays 80%^
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.					
Infertility **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.					
Note: Services where plan deductible applies are noted with a caret (**^**)					

Benefit	Inpatient Hospital Facility		Inpatient Professional Services	
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network
Organ Transplants	Plan pays 100% ^	Plan pays 80% ^	Plan pays 100% ^	Plan pays 80% ^
• Travel Maximum - Lifesource Facility: Unlimited				
Note: Services where plan deductible applies are noted with a caret (**^**)				

Benefit	Inpatient	Outpatient - Physician's Office	Outpatient – All Other Services
	In-Network	In-Network	In-Network
Mental Health	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^
Substance Use Disorder	Plan pays 80% ^	Plan pays 80% ^	Plan pays 80% ^
Note: Services where plan deductible applies are noted with a caret (**^**)			
Notes: Detox is covered under medical • Unlimited maximum per Contract Year • Services are paid at 100% after you reach your out-of-pocket maximum • Inpatient includes Residential Treatment • Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization			

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Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network
Cost Share and Supply	
Cigna Pharmacy Plus Cost Share • Retail – up to 30-day supply • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $15 ^ Preferred Brand: You pay $30 ^ Non-Preferred Brand: You pay $50 ^ **Home Delivery (per 90-day supply):** Generic: You pay $30 ^ Preferred Brand: You pay $60 ^ Non-Preferred Brand: You pay $100 ^

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.

Preventive Drugs:

In-Network Preventive drugs and products will not be subject to deductible. In addition, Federally required preventive drugs will not be subject to deductible and will be provided at no charge. This applies to drugs for:

- Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency

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Additional Drugs Covered

Prescription Drug List:

Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Self Administered injectables are covered.
- Federally required contraceptive devices and drugs are covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered
- Non-Sedating Anti-histamines are not covered
- Ulcer Drugs (Proton Pump Inhibitors/PPI) are not covered
- Prescription smoking cessation drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
    - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
    - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
    - Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific medications.
- Prior authorization is required on specialty medications but quantity limits may apply.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.

High Blood Pressure (ACEI/ARB), Cholesterol Lowering (STATIN),

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication
- 0 days grace period
- First Fill Pay and Educate included

Bladder Problems (OAB), Osteoporosis (Bone), ADD/ADHD (ADHD), Allergy (Nasal Steroids), Depression (SSRI/SNRI), Sleep Disorders (HYPNOTICS), Asthma (ASTHMA), Skin Conditions (TI), Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication
- 60 days grace period

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Pharmacy Program Information

- First Fill Pay and Educate included

Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

Additional Information

Case Management
Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Cigna Well Informed Program • Preference Sensitive Care • Educate and Refer	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester)

Medicare Coordination
Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B as permitted by the Social Security Act of 1965** as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

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Additional Information

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions
In Network: Coordinated by your physician

Pre-Certification - Continued Stay Review - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In Network: Coordinated by your physician

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologist, Pathologist and Anesthesiologist
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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Exclusions

What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

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Exclusions

- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs or weight loss programs .
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

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Exclusions

- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone or facsimile consultations.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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EHB State: CO

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El documento de Resumen de Beneficios y Cobertura (SBC) le ayudará a elegir un plan médico. El SBC le muestra cómo el plan y usted compartirían el costo de los servicios de atención médica cubiertos. NOTA: La información sobre los costos de este plan (que reciben el nombre de primas) se proporcionará por separado. Éste es solo un resumen. Para obtener más información sobre su cobertura o una copia de los términos completos de la cobertura, consulte www.kp.org/plandocuments o llame al 1-800-249-5005 o a la línea TTY al 711. Para consultar las definiciones generales de los términos comunes, como cantidad aprobada, saldo de facturación, coseguro, copago, deducible, proveedor u otro término que aparezca subrayado, consulte el Glosario en www.HealthCare.gov/sbc-glossary/.com o llame al 1-800-249-5005 o a la línea TTY al 711 y pida una copia.

Preguntas importantes	Respuestas	¿Por qué es importante?
¿Qué es el deducible general?	**$1,500** por individuo/**$3,000** por familia.	Por lo general, usted debe pagar todos los costos de los proveedores hasta el monto del deducible, antes de que el plan comience a pagar. Si usted tiene otros miembros de la familia en la póliza, se debe alcanzar el deducible general de la familia antes de que el plan comience a pagar.
¿Hay otros servicios cubiertos antes de que alcance su deducible?	**Sí**, servicios preventivos.	Este plan cubre algunos artículos y servicios, incluso si usted no ha alcanzado el monto del deducible. Pero podría aplicarse un copago o coseguro. Por ejemplo, este plan cubre ciertos servicios preventivos sin costo compartido y antes de que alcance su deducible. Consulte una lista de los servicios preventivos cubiertos en https://www.healthcare.gov/coverage/preventive-care-benefits/.
¿Hay otros deducibles para servicios específicos?	**No**.	Usted no tiene que pagar deducibles para servicios específicos, pero debe consultar el cuadro que comienza en la página 2 para obtener los precios de otros servicios cubiertos por el plan.
¿Cuál es el límite para los gastos del bolsillo del plan?	**$3,000** por individuo/**$6,000** por familia.	El límite para los gastos del bolsillo es la cantidad máxima que usted pagará en un año por los servicios cubiertos. Si usted tiene otros miembros de la familia en el plan, se deben alcanzar los límites generales de gastos del bolsillo de la familia.
¿Cuáles son las expensas que no cuentan para el límite de gastos del bolsillo?	Primas, cargos por saldo de facturación y atención médica que no cubre este plan.	Si bien usted paga estos costos, los mismos no se tendrán en cuenta para el límite de gastos del bolsillo.
¿Pagará menos si usa un proveedor de la red?	**Sí**. Consulte www.kp.org o llame al 1-855-249-5005 o a la línea TTY al 711 para obtener una lista de los proveedores del plan.	Este plan usa un proveedor de la red. Usted pagará menos si usa un proveedor de la red del plan. Pagará más si usa un proveedor fuera de la red, y es posible que reciba una factura de un proveedor por la diferencia entre el cargo del proveedor y lo que su plan paga (saldo de facturación). Tenga en cuenta que su proveedor de la red podría usar algún proveedor fuera de la red para algunos servicios (como pruebas de laboratorio). Consulte a su proveedor antes de recibir los servicios.
¿Necesito un referido para ver un especialista?	**No**.	Puede ver al especialista que elija sin un referido.

Todos los costos por **copagos** y **coseguros** que se muestran en el cuadro son después de haber alcanzado su **deducible**, en caso de que se aplique un **deducible**.

Eventos médicos comunes	Los servicios que podría necesitar	Lo que usted pagará		Limitaciones, excepciones e información importante
		Proveedor del plan (usted pagará el mínimo)	Proveedor fuera del plan (usted pagará el máximo)	
Si se atiende en la clínica o consultorio del proveedor médico	Consulta con su médico principal para tratar una condición o herida	20% de coseguro	No está cubierto	ninguna
	Consulta con un especialista	20% de coseguro	No está cubierto	ninguna
	Servicios preventivos/ evaluaciones/ vacunas	Sin costo	No está cubierto	Usted tendrá que pagar por los servicios que no son preventivos. Pregunte a su proveedor si los servicios que necesita son preventivos. Luego, consulte lo que su plan pagará. No está sujeto al deducible
Si tiene que hacerse un examen	Exámenes de diagnóstico (radiografías, análisis de sangre)	Radiografías: 20% de coseguro; pruebas de laboratorio: 20% de coseguro	No está cubierto	ninguna
	Imágenes (CT/PET scan, MRI)	20% de coseguro	No está cubierto	ninguna
Si necesita un medicamento Para más información sobre la **cobertura de medicamentos** visite **www.kp.org**.	Medicamentos genéricos	Al por menor: $20 de copago; orden por correo: $40 de copago	No está cubierto	Sujeto a las pautas de la lista de medicamentos; los medicamentos de marca no preferidos deben autorizarse mediante el proceso para medicamentos no preferidos. Según orden federal, los artículos de venta libre tienen cobertura con una receta médica cuando se surten en una farmacia de Kaiser Permanente. Los medicamentos preventivos en la lista de medicamentos preventivos de KP no tienen costo. Para los miembros del Sur de Colorado: los medicamentos de mantenimiento deben surtirse en una farmacia de las oficinas médicas de Kaiser Permanente o a través del servicio de orden por correo de Kaiser Permanente. Cubre hasta un suministro de 30 días (receta médica al por menor); un suministro de 31 a 90 días (receta médica ordenada por correo)
	Medicamentos de marca preferidos	Al por menor: $40 de copago; orden por correo: $80 de copago	No está cubierto	
	Medicamentos de marca no preferidos	Al por menor: $60 de copago; orden por correo: $120 de copago	No está cubierto	
	Medicamentos especiales	Se pueden aplicar gastos compartidos para medicamentos genéricos, de marca o no preferidos	No está cubierto	

Eventos médicos comunes	Los servicios que podría necesitar	Lo que usted pagará		Limitaciones, excepciones e información importante
		Proveedor del plan (usted pagará el mínimo)	Proveedor fuera del plan (usted pagará el máximo)	
Si le hacen una cirugía ambulatoria	Arancel del centro (clínica)	20% de coseguro	No está cubierto	ninguna
	Tarifa del médico/cirujano	20% de coseguro	No está cubierto	ninguna
Si necesita atención inmediata	Atención en la sala de emergencias	20% de coseguro	20% de coseguro	ninguna
	Traslado médico de emergencia	20% de coseguro	20% de coseguro	ninguna
	Cuidado urgente	20% de coseguro	20% de coseguro	Proveedores fuera del plan: están cubiertos solamente cuando usted se encuentra fuera del área de servicio
Si lo admiten al hospital	Arancel del hospital (habitación)	20% de coseguro	No está cubierto	ninguna
	Tarifa del médico/cirujano	20% de coseguro	No está cubierto	ninguna
Si necesita servicios de salud mental, de conducta o de abuso de sustancias	Servicios para pacientes ambulatorios	20% de coseguro	No está cubierto	ninguna
	Servicios para pacientes internados	20% de coseguro	No está cubierto	ninguna
Si está embarazada	Visitas al consultorio	20% de coseguro	No está cubierto	ninguna
	Servicios profesionales para el parto			
	Servicios del centro de atención para partos			

Eventos médicos comunes	Los servicios que podría necesitar	Lo que usted pagará		Limitaciones, excepciones e información importante
		Proveedor del plan (usted pagará el mínimo)	Proveedor fuera del plan (usted pagará el máximo)	
Si necesita servicios de recuperación u otras necesidades especiales	Cuidado de la salud en el hogar	20% de coseguro	No está cubierto	Limitado a menos de 8 horas por día y 28 horas por semana
	Servicios de rehabilitación	Servicios para pacientes internados: 20% de coseguro; servicios para pacientes ambulatorios: 20% de coseguro	No está cubierto	Paciente internado: las hospitalizaciones en centros multidisciplinarios se limitan a 60 días por enfermedad por año. Paciente ambulatorio: las consultas ambulatorias se limitan a 20 consultas por terapia, por año (los trastornos relacionados con el autismo no están sujetos al límite de consultas)
	Servicios de recuperación de las habilidades	20% de coseguro	No está cubierto	Las consultas ambulatorias se limitan a 20 consultas por terapia, por año (los trastornos relacionados con el autismo no están sujetos al límite de consultas)
	Cuidado de enfermería especializado	20% de coseguro	No está cubierto	Limitado a 100 días por año
	Equipo médico duradero	20% de coseguro	No está cubierto	La cobertura se limita a los artículos de nuestra lista de DME. 20% de coseguro para las prótesis de brazos y piernas
	Cuidado de hospicio	20% de coseguro	No está cubierto	ninguna
Si su hijo necesita servicios dentales o de la vista	Examen de los ojos para niños	20% de coseguro	No está cubierto	Para obtener los servicios de un oftalmólogo, vea la sección “Consulta con un especialista”
	Anteojos para niños	No está cubierto	No está cubierto	ninguna
	Consulta dental para niños	No está cubierto	No está cubierto	ninguna

Servicios excluidos y otros servicios cubiertos:

Los servicios que su plan generalmente NO cubre (consulte la póliza y los documentos del plan para obtener más información y una lista de otros servicios excluidos).		
• Acupuntura • Atención domiciliaria con enfermera de custodia/atención de largo plazo • Atención que no sea de emergencia cuando viaja fuera de los EE. UU. • Atención quiropráctica	• Audífonos con límites (adultos) • Cirugía bariátrica • Cirugía estética • Cuidado de los pies de rutina	• Tratamiento para la infertilidad • Servicios dentales de rutina (adultos) • Programas para perder peso

Otros servicios cubiertos (podrían aplicarse limitaciones a estos servicios. Esta es una lista parcial. Consulte los documentos del plan).		
• Audífonos con límites	• Cuidado de los ojos de rutina	• Enfermería privada

Su derecho para continuar con la cobertura: Estas son agencias que pueden ayudarle si desea continuar con la cobertura cuando termine. La información de contacto de esas agencias es: el plan al 1-855-249-5005 o a la línea TTY al 711. También puede comunicarse al departamento de seguros de su estado, a la Administración de Seguridad de Beneficios del Empleado del Departamento de Trabajo de los Estados Unidos al 1-866-444-3272 o en www.dol.gov/ebsa, o al Departamento de Salud y Servicios Humanos de los Estados Unidos al 1-877-267-2323 x61565 o en www.cciio.cms.gov. Es posible que también cuente con otras opciones de cobertura, como adquirir un seguro de cobertura individual por medio del Mercado de Seguros Médicos. Para obtener más información sobre el Mercado de Seguros Médicos, visite www.HealthCare.gov o llame al 1-800-318-2596.

Su derecho a presentar una queja o una apelación: Hay agencias que pueden ayudarle en caso de que tenga una queja contra del plan por la denegación de una reclamación. Esto recibe el nombre de queja o apelación. Para obtener más información sobre sus derechos, consulte la explicación de beneficios que recibirá por esa reclamación médica. Los documentos del plan también proporcionan información completa acerca de cómo presentar una reclamación, apelación o queja por cualquier motivo ante el plan. Si desea obtener más información sobre sus derechos, este aviso, o necesita ayuda comuníquese con el plan al 1-855-249-5005 o a la línea TTY al 711; con la Administración de Seguridad de Beneficios del Empleado del Departamento de Trabajo de los Estados Unidos al 1-866-444-3272 o en www.dol.gov/ebsa/healthreform; o con la División de Seguros de Colorado, sección Asuntos del Consumidor en 1560 Broadway, Ste 850, Denver, CO 80202 o al: 303-894-7490 (dentro del estado, línea gratuita: 800-930-3745), o por correo electrónico a: insurance@dora.state.co.us.

¿Provee Cobertura Esencial Mínima este plan? **Sí.**
Si usted no tiene Cobertura Esencial Mínima durante un mes, tendrá que hacer un pago cuando presente su declaración de impuestos, a menos que califique para una excepción del requisito de que usted debe tener cobertura de salud para ese mes.

¿Satisface este plan el Estándar de Valor Mínimo? **Sí.**
Si el plan no cumple con los Estándares de Valor Mínimo, usted podría ser elegible para un crédito tributario para el pago de primas que le ayudará a pagar un plan por medio del Mercado de Seguros Médicos.

Servicios de Acceso en Distintos Idiomas:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005.
Consulte la sección “Ayuda en su idioma” al final de este Resumen de Beneficios y Cobertura.

Para ejemplos sobre cómo este plan paga por los servicios en una situación médica específica consulte la siguiente sección.

Para obtener más información acerca de las limitaciones y excepciones, consulte los documentos del plan o la póliza en www.kp.org/plandocuments, o llame al 1-800-249-5005 o a la línea TTY al 711.

Sobre los ejemplos de cobertura:

Ésta no es una herramienta de cálculo de costos Los tratamientos que se muestran solo son ejemplos de cómo el plan podría cubrir la atención médica. Sus costos reales serán diferentes dependiendo de los servicios reales que reciba, de los precios que cobren los proveedores y muchos otros factores. Preste atención a los montos del costo compartido (deducibles, copagos y coseguro) y servicios excluidos del plan. Use esta información para comparar la parte de los costos que podría pagar con un plan de salud diferente. Tome en cuenta que los ejemplos de cobertura están basados en la cobertura de usted únicamente.

Peg tendrá un bebé
(9 meses de atención prenatal dentro de la red y un parto en el hospital)

Deducible general del plan	**$1,500**
Especialista *[costo compartido]*	**20%**
Hospital (centro) *[costo compartido]*	**20%**
Otro *[costo compartido]*	**20%**

Este evento de EJEMPLO incluye servicios como:
Visitas al consultorio de un especialista (*atención prenatal*)
Servicios profesionales para el parto
Servicios del centro de atención para partos
Pruebas de diagnóstico *(ultrasonidos y análisis de sangre)*
Consultas con un especialista (*anestesia*)

Costo total del ejemplo	**$12,800**
En este ejemplo, Peg pagaría:	
Costo compartido	
Deducibles	$1,500
Copagos	$0
Coseguro	$1,500
Lo que no está cubierto	
Límites o exclusiones	$60
El total que Peg pagaría es	**$3,060**

Control de la diabetes tipo 2 de Joe
(un año de control rutinario de la enfermedad dentro de la red)

Deducible general del plan	**$1,500**
Especialista *[costo compartido]*	**20%**
Hospital (centro) *[costo compartido]*	**20%**
Otro *[costo compartido]*	**20%**

Este evento de EJEMPLO incluye servicios como:
Visitas al consultorio con un médico de atención primaria (*incluye educación sobre las enfermedades*)
Pruebas de diagnóstico (*análisis de sangre*)
Medicamentos recetados
Equipo médico duradero (*glucómetro*)

Costo total del ejemplo	**$7,400**
En este ejemplo, Joe pagaría:	
Costo compartido	
Deducibles	$1,500
Copagos	$600
Coseguro	$400
Lo que no está cubierto	
Límites o exclusiones	$60
El total que Joe pagaría es	**$2,560**

Fractura simple de Mia
(visita a la sala de emergencias y atención médica de seguimiento dentro de la red)

Deducible general del plan	**$1,500**
Especialista *[costo compartido]*	**20%**
Hospital (centro) *[costo compartido]*	**20%**
Otro *[costo compartido]*	**20%**

Este evento de EJEMPLO incluye servicios como:
Atención en la sala de emergencias (*incluye suministros médicos*)
Pruebas de diagnóstico (*radiografías*)
Equipo médico duradero (*muletas*)
Servicios de rehabilitación (*fisioterapia*)

Costo total del ejemplo	**$1,900**
En este ejemplo, Mia pagaría:	
Costo compartido	
Deducibles	$1,500
Copagos	$0
Coseguro	$90
Lo que no está cubierto	
Límites o exclusiones	$0
El total que Mia pagaría es	**$1,590**

El **plan** sería responsable de los demás costos de estos servicios cubiertos de EJEMPLO.