AGA Cigna PPO 3000 Plan

Coverage for: Individual and Family | Plan Type: PPO

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, call Insurance Design Administrators at **1-855-606-9294**. 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 www.healthcare.gov/sbc-glossary/ or call **1-855-606-9294** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $3,000/Individual; $6,000/Family. For out-of-network providers: $6,000/Individual; $12,000/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, some services with network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 network providers: $8,150/Individual; $16,300/Family For out-of-network providers: No 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 must meet their own out-of-pocket limits.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan does not cover.	Although you may pay these expenses, they do not count towards the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.cigna.com, choose PPO, Choice Fund PPO or call 1-855-606-9294 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
		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	$40 copay/office visit deductible waived	40% coinsurance	None
	Specialist visit	$60 copay/office visit	40% coinsurance	Coverage for chiropractic services is limited to thirty (30) visits per calendar year. Network providers coverage for chiropractic services is limited to 70% of cost per visit and out-of-network provider coverage is limited to 60% of cost per visit. Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied. Acupuncture is not covered.
	Preventive care/screening/ immunization	No charge	Not covered	Coverage is limited to one general medical exam each calendar year, plus recommended screenings and immunizations. 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)	0% coinsurance deductible waived	40% coinsurance	Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs.
	Imaging (CT/PET scans, MRIs)	30% coinsurance deductible waived	40% coinsurance	Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs. Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling Insurance Design Administrators: 1-855-606-9294 Retail provider: Broadreach Medical Resources (BMR) 1-866-718-2375 Mail order provider: Affordable Scripts 1-800-325-7995	Generic drugs	$0 copay retail/$0 mail	Not covered	Covers up to 34-day supply retail. 90-day supply mail order maximum.
	Preferred brand drugs	25% coinsurance	Not covered	
	Non-preferred brand drugs	50% coinsurance	Not covered	
	Specialty drugs	Not covered	Not covered	Contact Payer Matrix at 1-877-305-6202.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	No coverage for air transportation. Non-emergency is paid at the 60% coinsurance after deductible
	Urgent care	$40 copay/office visit deductible waived.	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Coverage is limited to 120 days per confinement. Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	40% coinsurance	Preauthorization is required by calling DJ O'Grady Consultants at 1-212-206-7898. If you don't get preauthorization, your claim can be denied.
	Inpatient services	30% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$40 copay/office visit	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Confinements over 96 hours require preauthorization by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied. Dependent pregnancy is not covered.
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Rehabilitation services	30% coinsurance	40% coinsurance	Outpatient limited to 30 visits all combined Therapy services per calendar year. Inpatient limited to 120 days per calendar year combined. Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Habilitation services	30% coinsurance	40% coinsurance	Certain services covered for behavioral health, mental health and substance use disorders and developmental disabilities. Refer to specific services.
	Skilled nursing care	30% coinsurance	40% coinsurance	Limited to 120 days. Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Durable medical equipment	30% coinsurance	40% coinsurance	Shoe inserts are covered for up to a maximum of $500 every 2 years. For equipment over $500 preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
	Hospice services	30% coinsurance	40% coinsurance	Coverage is limited to 180 days maximum Preauthorization is required by calling 1-855-606-9294. If you don't get preauthorization, your claim can be denied.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	In-network only up to plan maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	In-network only up to plan maximum.

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	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• 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	• Dental care (children)	• Routine eye care (children)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. The contact information for the plan is Insurance Design Administrators, 111 Bauer Drive, Oakland, New Jersey 07436, telephone: 1-855-606-9294. 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 more information about your rights, this notice, or assistance, contact: Insurance Design Administrators, 111 Bauer Drive, Oakland, New Jersey 07436, telephone: 1-855-606-9294. Insurance Design Administrators office hours are 8:30 A.M. to 4:30 P.M. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at 105 East 22nd Street, 8th floor, New York, NY 10010, 1-888-614-5400 or http://www.communityhealthadvocates.org.

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:
Para obtener asistencia en Español, llame al 1-855-606-9294.

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 copayment** **$60**
- **Hospital (facility) coinsurance** **30%**
- **Surgery 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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$240
Coinsurance	$2,838
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,078**

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**
- **Primary care copayment** **$40**
- **Branded drugs coinsurance** **25%**
- **Durable medical equipment 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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$160
Coinsurance	$732
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,892**

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

- **The plan's overall deductible** **$3,000**
- **Physical therapy coinsurance** **30%**
- **Emergency room (facility) coinsurance** **30%**
- **Durable medical equipment 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	**$5,000**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,600**

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