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, 888.816.3096. 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 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 Single/ $1,500 Family; Out-of-Network: $500 Single/$1,500 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. Outpatient Surgery, Preventive Care, Primary Care and Specialist Office 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/.
Are there other deductibles for specific services?	Yes. Prescriptions	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $2,500 Single/$12,700 Family; Out-of-Network: Unlimited Single/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?	Premiums, balance-billing charges, penalties and healthcare 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. Call 1.888.816.3096 or visit www.mycigna.com for a list of participating 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	$30 copay per visit	40% coinsurance	
	Specialist visit	$45 copay per visit	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.rxbenefits.com	Generic drugs	$10 30 day supply; $25 90 day supply	Not covered	$100 deductible per participant (waived for generic medications) 90 day supply available at retail or through mail order
	Preferred brand drugs	$35 30 day supply; $87.50 90 day supply	Not covered	
	Non-preferred brand drugs	$50 30 day supply; $125 90 day supply	Not covered	
	Specialty drugs	10% coinsurance or $100 (whichever is less)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit then 10% coinsurance	40% coinsurance	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	
	Emergency medical transportation	10% coinsurance	40% coinsurance	
	Urgent care	$45 copay per visit	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.healthplan.org.

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 copay per visit	40% coinsurance	
	Inpatient services	10% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$45 copay per visit	40% coinsurance	
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	
	Rehabilitation services	10% coinsurance	40% coinsurance	
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	60 days per calendar year
	Durable medical equipment	10% coinsurance	40% coinsurance	
	Hospice services	10% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Pediatric screening
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	Not covered	Pediatric screening

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
- Biofeedback
- Cosmetic surgery
- Eye care (adult)
- Foot care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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

- Chiropractic care
- Infertility treatment
- Private duty nursing

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: the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services 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

[* For more information about limitations and exceptions, see the plan or policy document at www.healthplan.org.

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: The Health Plan Appeals Coordinator at 1.888.816.3096 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1.855.577.7123.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1.855.577.7123.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.healthplan.org.

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	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	10%

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	$14,150

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500.00
Copayments	$230.00
Coinsurance	$450.00
What isn't covered	
Limits or exclusions	$50.00
The total Peg would pay is	$1,230.00

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	10%

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	$6,100

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500.00
Copayments	$130.00
Coinsurance	$180.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	$810.00

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$200
Other *[cost sharing]*	10%

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

Total Example Cost	$2,400

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500.00
Copayments	$360.00
Coinsurance	$110.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$970.00

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