
 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: |
|---|---|--|
| <p>What is the overall deductible?</p> | <p>In-network: \$500 Single/ \$1,500 Family Out-of-Network: \$500 Single/\$1,500 Family</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Outpatient Surgery, Preventive Care, Primary Care and Specialist Office Visits</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>Yes. Prescriptions</p> | <p>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.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>In-Network \$2,500 Single/\$7,500 Family Out-of-Network \$8,550 Single/\$17,100 Family Out-of-Area \$5,000 Single/\$15,000 Family</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billing charges, amounts in excess of the Reference Based Price, penalties and healthcare this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. Call 1.888.816.3096 or visit www.mycigna.com for a list of participating providers.</p> | <p>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.</p> |

| | | |
|--|----|--|
| 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 copay retail; \$25 copay mail order | Not covered | Limited to 34-day supply retail, 90 day supply mail order. \$100 deductible per participant (waived for generic medications) |
| | Preferred brand drugs | \$35 copay retail; \$87.50 copay mail order | Not covered | |
| | Non-preferred brand drugs | \$50 copay retail; \$125 copay mail order | 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 | Maximum of three copays per period of confinement. |
| | 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 | \$45 copay per visit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$100 copay then 10% coinsurance | \$100 copay then 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 | \$100 copay then 10% coinsurance | \$100 copay then 40% coinsurance | Maximum of three copays per period of confinement. |
| 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 | Outpatient physical therapy up to 24 visits as prescribed by a physician within a 12 month period after a procedure. 60 days per calendar year |
| | Rehabilitation services | 10% coinsurance | 40% coinsurance | |
| | Habilitation services | 10% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | |
| | 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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Acupuncture Biofeedback Cosmetic surgery | <ul style="list-style-type: none"> Eye care (adult) Foot care | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private Duty Nursing (Inpatient) |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|--|---|---|
| <ul style="list-style-type: none"> Chiropractic care Hearing Aids (After deductible, covered at 100% Up to plan max of \$2,000 per ear, with 1 hearing aid per ear every 3 years.) | <ul style="list-style-type: none"> Infertility treatment | <ul style="list-style-type: none"> Private duty nursing (Outpatient) |

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

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

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 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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1.855.577.7123.

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, kwijigo holne' 1.855.577.7123.

————— *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](#) \$500
- [Specialist](#) [[copayment](#)] \$45
- Hospital (facility) [[copayment](#)] \$200
- Other [[coinsurance](#)] 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$500.00 |
| Copayments | \$140.00 |
| Coinsurance | \$1,200.00 |
| What isn't covered | |
| Limits or exclusions | \$0.00 |
| The total Peg would pay is | \$1,840.00 |

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](#) [[copayment](#)] \$45
- Hospital (facility) [[copayment](#)] \$200
- Other [[coinsurance](#)] 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|-----------------|
| Deductibles | \$500.00 |
| Copayments | \$250.00 |
| Coinsurance | \$170.00 |
| What isn't covered | |
| Limits or exclusions | \$0.00 |
| The total Joe would pay is | \$920.00 |

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [[copayment](#)] \$45
- Hospital (facility) [[copayment](#)] \$200
- Other [[coinsurance](#)] 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|-----------------|
| Deductibles | \$500.00 |
| Copayments | \$300.00 |
| Coinsurance | \$60.00 |
| What isn't covered | |
| Limits or exclusions | \$0.00 |
| The total Mia would pay is | \$860.00 |