
 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. Preventive care, primary care, specialist, urgent care, emergency and outpatient surgeries, and pharmacy.</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. \$100 for prescription drug coverage per participant. There are no other specific deductibles.</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</p>

		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 deductible waived	40% coinsurance after deductible	None
	Specialist visit	\$45 copay per visit deductible waived	40% coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	40% coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	40% coinsurance after deductible	None
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 days 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 deductible waived	40% coinsurance after deductible	None
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	\$100 copay per visit deductible waived	\$100 copay per visit deductible waived	None

* 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)	
	Emergency medical transportation	10% coinsurance after deductible	40% coinsurance after deductible	None
	Urgent care	\$45 copay per visit deductible waived	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay then 10% coinsurance after deductible	\$100 copay then 40% coinsurance after deductible	Maximum of three copays per period of confinement.
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay per visit deductible waived	40% coinsurance after deductible	None
	Inpatient services	\$100 copay then 10% coinsurance after deductible	\$100 copay then 40% coinsurance after deductible	Maximum of three copays per period of confinement.
If you are pregnant	Office visits	\$45 copay per visit deductible waived	40% coinsurance after deductible	None
	Childbirth/delivery professional services	10% coinsurance after deductible	40% coinsurance after deductible	None
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	40% coinsurance after deductible	None
	Rehabilitation services	10% coinsurance after deductible	40% coinsurance after deductible	Outpatient physical therapy up to 24 visits as prescribed by a physician within a 12-month period after a procedure.
	Habilitation services	10% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	10% coinsurance after deductible	40% coinsurance after deductible	60 days per calendar year
	Durable medical equipment	10% coinsurance after deductible	40% coinsurance after deductible	None

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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)	
	Hospice services	10% coinsurance after deductible	40% coinsurance after deductible	None
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	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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
- 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.)

- 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.)
- Infertility treatment
- 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 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,

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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) [\[copayment\]](#) \$100
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500.00
Copayments	\$140.00
Coinsurance	\$1,200.00
<i>What isn't covered</i>	
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) [\[copayment\]](#) \$100
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500.00
Copayments	\$250.00
Coinsurance	\$170.00
<i>What isn't covered</i>	
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) [\[copayment\]](#) \$100
- 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
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In this example, Mia would pay:

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