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/**$7,500** Family Out-of-Network **$8,550** Single/**$17,100** Family Out-of-Area **$5,000** Single/**$15,000** 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, amounts in excess of the Reference Based Price, 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**	None
	Specialist visit	$45 **copay** per visit	40% **coinsurance**	None
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	None
If you have a test	Diagnostic test (x-ray, blood work)	10% **coinsurance**	40% **coinsurance**	None
	Imaging (CT/PET scans, MRIs)	10% **coinsurance**	40% **coinsurance**	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 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)	10% **coinsurance**	40% **coinsurance**	Maximum of three **copays** per period of confinement.
	Physician/surgeon fees	10% **coinsurance**	40% **coinsurance**	None
If you need immediate medical attention	Emergency room care	$100 **copay** per visit	$100 **copay** per visit	None
	Emergency medical transportation	10% **coinsurance**	40% **coinsurance**	None
	Urgent care	$45 **copay** per visit	$45 **copay** per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 **copay** then 10% **coinsurance**	$100 **copay** then 40% **coinsurance**	None
	Physician/surgeon fees	10% **coinsurance**	40% **coinsurance**	None

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**	None
	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**	None
	Childbirth/delivery professional services	10% **coinsurance**	40% **coinsurance**	None
	Childbirth/delivery facility services	10% **coinsurance**	40% **coinsurance**	None
If you need help recovering or have other special health needs	Home health care	10% **coinsurance**	40% **coinsurance**	None
	Rehabilitation services	10% **coinsurance**	40% **coinsurance**	Outpatient physical therapy up to 24 visits as prescribed by a physician within a 12 month period after a procedure.
	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**	None
	Hospice services	10% **coinsurance**	40% **coinsurance**	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	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
- 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, 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, 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 *[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**

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