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 1-844-258-2759. 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.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or call 1-844-258-2759 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: **$500** individual / **$1,000** family For out-of-network providers: **$1,000** individual / **$2,000** 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. Preventive care and in-network primary care office visits are covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: **$5,500** individual / **$11,000** family; For out-of-network providers: **$10,000** individual / **$20,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they each have to meet their own out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, penalties, balance-billed charges, 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, Cigna. Call 1-844-258-2759 or visit www.mycigna.com for a list of in-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
		In-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	$20 copay per visit	Deductible / 40% coinsurance	In-network office visit copay applies to all eligible services performed in the physician's office.
	Specialist visit	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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 from Magellan Rx at 1-800-424-0472 or www.magellanrx.com	Generic drugs	$10 copay retail per prescription $20 copay mail order per prescription		Retail – up to a 34 day supply – 1 copay per prescription Retail – up to a 93 day supply for maintenance drugs at specified local pharmacies – 2 copays per prescription Mail order – up to a 93 day supply. No charge for over-the-counter Claritin and Prilosec (with a prescription from the physician). Prescription copays apply toward the medical out-of-pocket limit. Once the medical out-of-pocket limit has been met, prescription copays will no longer apply for the remaining calendar year.
	Preferred brand drugs	$30 copay retail per prescription $60 copay mail order per prescription		
	Non-preferred brand drugs	$50 copay retail per prescription $100 copay mail order per prescription		
	Specialty drugs	20% of prescription cost up to $250 maximum per prescription Copay amounts may differ for Specialty drugs subject to the Smart Rx Assist Program, which is a part of the **Medical** plan, not the pharmacy benefit.**		Specialty drugs may require prior authorization. Call 1-800-424-0472. **The Medical plan has implemented the Smart Rx Assist Program in order to utilize financial rebates, discounts and/or assistance programs offered by third-party specialty drug manufacturers. The plan has imposed special utilization requirements for certain specialty drugs. The list of specialty drugs subject to this program can be found here: https://myhealth.healthsmart.com/Login.aspx?ReturnUrl=%2fsecure%2fDefault.aspx For more information about the Smart Rx Assist Program, please call HealthSmart Rx at 1-800-681-6912.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required for some procedures. Call HealthSmart 1-844-258-2759.
	Physician/surgeon fees	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	Deductible / 20% coinsurance	Deductible / 20% coinsurance	In-Network deductible and out-of-pocket limit apply to out-of-network charges.
	Emergency medical transportation	Deductible / 20% coinsurance	Deductible / 20% coinsurance	In-Network deductible and out-of-pocket limit apply to out-of-network charges.
	Urgent care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.
	Physician/surgeon fees	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible / 20% coinsurance	In-Network Deductible / 20% coinsurance	----------none----------
	Inpatient services	Deductible / 20% coinsurance	In-Network Deductible / 20% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.
If you are pregnant	Office visits	No charge	Deductible / 40% coinsurance	No charge for in-network routine prenatal care.
	Childbirth/delivery professional services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Childbirth/delivery facility services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.
	Rehabilitation services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Inpatient rehabilitation requires precertification. Call HealthSmart 1-844-258-2759.
	Habilitation services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Outpatient speech therapy requires precertification. Call HealthSmart 1-844-258-2759.
	Skilled nursing care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required, call HealthSmart 1-844-258-2759.
	Durable medical equipment	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precertification is required for some items. Call HealthSmart 1-844-258-2759.
	Hospice services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)

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

- Acupuncture
- Bariatric surgery (Must meet medical necessity guidelines.)
- Chiropractic care
- Hearing aids (Limit $1,400 per ear once every three years.)
- Infertility treatment (In-vitro fertilization limited to 3 per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient only.)
- Routine foot care (Due to metabolic disorder or peripheral vascular disease only.)
- Weight loss programs

Your Rights to Continue Coverage:

For more information on your rights to continue coverage, contact the plan at 1-844-258-2759. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. 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 Claims Administrator at 1-844-258-2759. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 1-844-258-2759. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-258-2759. Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-844-258-2759. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-258-2759.

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 coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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 (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,410**

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 coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,100**

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

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$450
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950***

***Accidental injury benefit: Plan pays the first $500 of charges due to an accident.**

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