




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 : \$1,500 individual / \$3,000 family For out-of-network providers : \$4,000 individual / \$8,000 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 , the family deductible amount must be met before benefits are paid for any member of the family, with the exception of wellness care.
Are there services covered before you meet your deductible ?	Yes. Preventive care is 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 : \$6,500 self-only coverage / \$11,000 family (with one individual not to exceed \$8,000) For out-of-network providers : \$10,000 self-only coverage / \$30,000 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, 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	Deductible then \$30 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	After deductible \$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). Deductible does not apply to certain preventive medications. 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	After deductible \$30 copay retail per prescription \$60 copay mail order per prescription		
	Non-preferred brand drugs	After deductible \$50 copay retail per prescription \$100 copay mail order per prescription		
	Specialty drugs	After deductible 20% of prescription cost up to \$250 maximum per prescription		Specialty drugs may require prior authorization. Call 1-800-424-0472.
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-----

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 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.
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-----

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 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 .)			
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care 	<ul style="list-style-type: none"> • Routine eye care (Adult) 	
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"> • Acupuncture • Bariatric surgery (Must meet medical necessity guidelines.) • Chiropractic care 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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, kwijigo 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	\$1,500
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$40
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,540

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$400
Coinsurance	\$150
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,050

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000