

 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, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

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Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network \$5,000 /Individual; \$10,000/family Out-of-network \$10,000 /Individual; \$20,000/family	Generally, you must pay the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Primary Care Physician visits, prescription drugs and urgent care visits	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$8,150/Individual; \$16,300 family, in-network. Out-of-network Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket-limits</u> .
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.mycigna.com _____	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what you plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	This plan will pay some or all of the costs to see a specialist for covered services.



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	\$20 copay : deductible does not apply.	50% coinsurance	None
	Specialist visit	\$60 copay /visit: : deductible does not apply.	50% coinsurance	None
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None. Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Pre-cert required. Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs.
If you need drugs to treat your illness or condition For information visit www.empirxhealth.com or call (877) 241-7123	Generic drugs	\$0 copay retail/\$0 mail.	Not covered	Covers up to 34-day supply retail. 90-day supply mail order maximum. Retail claims - EmpiRx: (877) 241-7123 Mail order claims: (877) 241-7123 Specialty drugs are available through Payer Matrix only at 1-877-305-6202.
	Preferred brand drugs	25% coinsurance .	Not covered	
	Non-preferred brand drugs	50% coinsurance .	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Pre-certification required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Pre-certification required.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	No coverage for Air Transport
	Urgent care	\$20 copay /visit : deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-certification required. Limited to 120 days.

[* For more information about limitations and exceptions, see the SPD.]

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)	
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required. Limited to 120 days.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Normal delivery/48 hours. Cesarean section/96 hours. Pre-certification is required.
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required. Limited to 120 days.
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required.
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient: limited to 30 visits per calendar year. Inpatient limited to 120 days per calendar year. Pre-certification is required.
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification required. Limited to 120 days.
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Shoe inserts are covered for up to a maximum payment of \$500 every 2 years.
	Hospice services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Maximum of six months and three bereavement counseling sessions. Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	In-network only up to Plan maximum.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	In-network only up to Plan maximum.

[* For more information about limitations and exceptions, see the SPD.]

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](#).)

- Bariatric surgery
- Cochlear implants
- Cosmetic surgery
- Infertility treatment
- Acupuncture
- Dependent Pregnancy
- Long-term care
- No coverage outside the U.S.
- Private-duty nursing
- Transplants
- Initial \$25,000 in medical charges resulting from a motor vehicle accident not covered
- Routine foot care
- Weight loss programs
- Hearing aids
- Dental care (adults)
- Routine eye care (adults)
- Pain Management

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

- Chiropractic care, up to 30 visits per year.
- Routine eye care exam, (dependent child only)
- Routine dental checkup (dependent child only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.

You may also contact the Department of Labor's Employee Benefits Security Administration at: 1-866-444-EBSA or www.dol.gov/ebsa/healthreform. 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](#) SPD provides complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#)

Does this plan provide Minimum Essential Coverage? [Yes]

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'

————— *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](#) \$5,000
- [Specialist \[cost sharing\]](#) 30%
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

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	\$8,000
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,900

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist \[cost sharing\]](#) \$60
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

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	\$5,500
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5000
Copayments	\$60
Coinsurance	\$132
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Joe would pay is	\$5,292

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist \[cost sharing\]](#) \$60
- [Hospital \(facility\) \[cost sharing\]](#) 30%
- [Other \[cost sharing\]](#) 30%

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	\$3,500
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$3,500