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 1-800-527-1647. 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 1-800-365-2589 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $600/person, $1,800/family. (When three family members each meet their individual deductible, the family deductible is met.) | 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 three family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Network preventive services, network office visits and prescription drugs 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? | In-network: coinsurance limit: $3,000/person, $5,000/family; out-of-pocket limit: $6,350/person, $12,700/family. Out-of-network: coinsurance limit: $9,000/person, unlimited/family; out-of-pocket limit: unlimited. | 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 limit until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Coinsurance limit: Premium, balance-billed charges, copays, plan deductibles, prescription drugs, dental and vision expenses, preauthorization penalties, and health care this plan doesn't cover. Out-of-pocket limit: Premium, balance-billed charges, dental and vision expenses, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| Will you pay less if you use a network provider? | Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers. For mental health/substance abuse treatment providers, call Mines & Associates at 1-800-873-7138. | 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/office visit and 25% coinsurance/procedures during office visit; deductible does not apply to office visit | 45% coinsurance | Network telehealth visit: $30 copay/visit. |
| | Specialist visit | $40 copay/visit; 25% coinsurance/ procedures during office visit; deductible does not apply to office visit. | 45% coinsurance | None. |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | 45% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-network limited to mammograms, pap smears, PSA testing and colonoscopies. |
| If you have a test | Diagnostic test (x-ray, blood work) | 25% coinsurance | 45% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | $75 copay/scan per day, plus 25% coinsurance | $75 copay/scan per day, plus 45% coinsurance | Preauthorization required; $100 benefit reduction if failure to preauthorize. |

* For more information about limitations and exceptions, see the plan or policy document.

| 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 drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.myCigna.com. | Generic drugs | Retail: $5 copay; Maintenance medication: $10 copay. Deductible does not apply. | Not covered | If you receive a brand name drug when a generic drug is available, you will pay the generic drug copay plus the difference in cost between the generic and brand name drug. Some exceptions apply.<br><br>Coverage is limited up to a 34-day supply (retail and specialty drugs) and 90-day supply for maintenance medication; certain drugs may be subject to preauthorization or step therapy; preauthorization is required for specialty drugs. |
| | Preferred brand drugs | Retail: 20% coinsurance up to $50/prescription; Maintenance medication: 20% coinsurance up to $100/prescription. Deductible does not apply. | Not covered | |
| | Non-preferred brand drugs | Retail: 30% coinsurance up to $75/prescription; Maintenance medication: 30% coinsurance up to $150/prescription. Deductible does not apply. | Not covered | |
| | Specialty drugs | 20% coinsurance up to $100/prescription. Deductible does not apply. | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 45% coinsurance | None. |
| | Physician/surgeon fees | 25% coinsurance | 45% coinsurance | |
| If you need immediate medical attention | Emergency room care | 25% coinsurance | 25% coinsurance | None. |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | |
| | Urgent care | 25% coinsurance | 25% coinsurance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% coinsurance | 45% coinsurance | Preauthorization is required. $100 penalty for failure to preauthorize. |
| | Physician/surgeon fees | 25% coinsurance | 45% coinsurance | None. |

* For more information about limitations and exceptions, see the plan or policy document.

| 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/office visit and 25% coinsurance for other outpatient services; deductible does not apply to office visit | 45% coinsurance | None. |
| | Inpatient services | 25% coinsurance | 45% coinsurance | Preauthorization is required. $100 penalty for failure to preauthorize. |
| If you are pregnant | Office visits | Applicable office visit copay/visit; 25% coinsurance/procedures during office visit; deductible does not apply to office visit | 45% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 25% coinsurance | 45% coinsurance | |
| | Childbirth/delivery facility services | 25% coinsurance | 45% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 25% coinsurance | 25% coinsurance | Coverage is limited to 40 days/year; preauthorization required; $100 benefit reduction if failure to preauthorize. |
| | Rehabilitation services | 25% coinsurance; 50% coinsurance/Speech Pathologist (non-Hospital) | 45% coinsurance; 50% coinsurance/Speech Pathologist (non-Hospital) | Coverage for Speech Pathologist limited to 50 days/year. |
| | Habilitation services | Not covered | Not covered | Coverage is excluded. |
| | Skilled nursing care | 25% coinsurance | 45% coinsurance | None. |
| | Durable medical equipment | 25% coinsurance | 45% coinsurance | Preauthorization required; $100 benefit reduction if failure to preauthorize. |
| | Hospice services | 25% coinsurance | 25% coinsurance | None. |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | None. |
| | Children's glasses | All charges in excess of two-calendar year limit | All charges in excess of two-calendar year period | Coverage limited to following two calendar year limits: $240 (single), $260 (bifocal), $290 (trifocal) for frames and lenses. |
| | Children's dental check-up | No charge | 20% coinsurance | Coverage limited to 2 visits/12 month period. |

* For more information about limitations and exceptions, see the plan or policy document.

## 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
- Cosmetic surgery, except to repair damage from an accident, that is incidental to or follows surgery that results from trauma or infection, to enable you to eat, or as required by law
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Bariatric surgery (specific criteria must be met)
- Chiropractic care (15 days/year maximum)
- Dental care (Adult), $1,000 / year - Preventive Only
- Routine eye care (Adult), up to two-calendar year limit, including exam
- Routine foot care

**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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) 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 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 Plan at 1-800-527-1647, Cigna at 1-800-Cigna24, or 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

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 1-800-244-6224.

*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.

## 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 | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

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 | $600 |
| Copayments | $20 |
| Coinsurance | $2,780 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $3,410 |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

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 | $130 |
| Copayments | $570 |
| Coinsurance | $1,060 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| The total Joe would pay is | $1,800 |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

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 | $600 |
| Copayments | $160 |
| Coinsurance | $290 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,050 |

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