




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, 1-888-721-2128. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-721-2128 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network providers</a> : \$250 individual / \$500 family <a href="#">Out-of-network providers</a> : \$7,000 individual / \$14,000 family Benefit Period: Plan Year	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> (Embedded).
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Prescription drugs</a> , <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network providers</a> : \$6,250 individual / \$12,500 family <a href="#">Out-of-network providers</a> : \$12,500 individual / \$25,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met (Embedded).
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. This plan uses Cigna PPO Network. A list of <a href="#">network providers</a> can be found at <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-997-1654	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after deductible	Telemedicine with \$0 cost share via Health Wallet at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or at 1-888-995-2759
	<a href="#">Specialist</a> visit to treat an injury or illness	\$35 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after deductible	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	50% <a href="#">coinsurance</a> after deductible	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.omnipbm.com/engage">www.omnipbm.com/engage</a> or call 1-888-478-3443	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> Retail \$40 <a href="#">copay</a> Mail Order	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> Retail \$80 <a href="#">copay</a> Mail Order	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$65 <a href="#">copay</a> Retail \$130 <a href="#">copay</a> Mail Order	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	20% Coinsurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required for certain services, for details call plan administrator. If preauthorization is not obtained benefit is subject to preauthorization penalty of 50% of the allowed.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	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 immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after deductible/per visit		All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after deductible/per visit		All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after deductible	None
	Inpatient services	20% <a href="#">coinsurance</a> after deductible/per visit	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
If you are pregnant	Office visits	\$35 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after deductible	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Maximum 60 visits per benefit period. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Maximum 60 visits per benefit period. Includes physical therapy, speech therapy, and occupational therapy. Therapy limits are not combined.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	

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)	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Maximum 60 visits per benefit period. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Preauthorization</a> is required for certain services, for details call plan administrator. If preauthorization is not obtained benefit is subject to preauthorization penalty of 50% of the allowed.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	Maximum 180 days per lifetime. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

#### 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](#).)**

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|--|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Advanced Infertility Services</li> <li>• Bariatric Surgery</li> <li>• Bereavement Counseling</li> <li>• Biofeedback</li> <li>• Cosmetic Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Care (Routine)</li> <li>• Hearing Aids</li> <li>• Long-Term Care</li> <li>• Maternity Care for dependent daughters</li> <li>• Non-Emergency Care outside US</li> <li>• Non-Emergency Care in the ER Setting</li> </ul> | <ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Routine Foot Care</li> <li>• TMJ Treatment</li> <li>• Vision Exam and Hardware</li> <li>• Weight Loss Programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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| <ul style="list-style-type: none"> <li>• Allergy injections</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care (Limited to 26 visits per benefit period.)</li> </ul> | <ul style="list-style-type: none"> <li>• Elective Sterilization</li> </ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-721-2128. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or

[www.cciio.cms.gov](http://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](http://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: 1-888-721-2128

**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 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 1-888-721-2128

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-721-2128

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-721-2128

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-721-2128

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$120
Coinsurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,910</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$250
Copayments	\$1,370
Coinsurance	\$372
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,047</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$250
Copayments	\$245
Coinsurance	\$172
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$667</b>