

Subject to plan allowable. 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 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.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network providers \$0/individual or \$0/family; For Non-network providers N/A	Generally, you must pay all 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 services 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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For Network providers \$5,000/individual or \$10,000/family; For Non-network providers \$5,000/individual or \$10,000/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 , balanced-billing charges, and health care 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 <u>network provider</u> ?	Yes. See www.mycigna.com for a list of participating providers	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> 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 your <u>plan</u> 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	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 12 visits per plan year.
	Specialist visit	\$25 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 12 visits per plan year.
	Preventive care/screening/ immunization	0% coinsurance	Not covered	Not covered if provided at a hospital. 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. Limited to 1 visit per year. Subject to plan allowable.
If you have a test	Diagnostic test (X-Ray & Lab)	Independent Lab and X-Ray: \$50 copay/visit	Not covered	Independent lab, does not include services provided in physician's office or hospital. Limited to 4 visits per year.
	Imaging (CT/PET scans, MRIs)	\$350 copay (Subject to Maximum Plan Allowable)	Not covered	Not covered if services are provided at a hospital. Limited to 3 per plan year. Preauthorization is required.
If you need drugs to treat your illness or condition	Generic drugs	20% copay /prescription for retail	Not covered	Only covers generic retail drugs including COVID-19 generics. No specialty drugs or brand drugs covered (except for base contraceptive benefit).
	Preferred brand drugs	20% copay/prescription for retail	Not covered	Limited to a 30-day supply (retail); Subject to formulary.
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 2 visit per plan year. Preauthorization is required.
	Physician/surgeon fees			

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 2 visit per plan year.
	<u>Emergency medical transportation</u>	\$250 copay (Subject to Maximum Plan Allowable)	Not covered	By land only. Limited to 2 transport per plan year
	<u>Urgent care</u>	\$50 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 3 visits per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 copay per admission (Subject to Maximum Plan Allowable)	Not covered	Limited to 10 days per plan year.
	Physician/surgeon fees	Included in Inpatient Hospitalization copay	Not covered	Limited to visits up to 10 days per plan year.
If you need mental health, behavioral health and substance abuse services	Outpatient services	\$25 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 12 specialists visits and 10 non-specialist visits per plan year. <u>Preventive services</u> are covered for mental, behavioral health or substance abuse. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Inpatient services	\$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 10 days per plan year.
If you are pregnant	Office visits	Included In Professional Services <u>copay</u>	Not covered	See Professional Services limitations.
	Childbirth/delivery professional services	\$350 copay	Not covered	Professional Services only, including standard office visits.
	Childbirth/delivery facility services	0%	Not covered	Considered an Inpatient Hospital Stay. Refer to limitations.

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	\$25 copay	Not covered	Limited to 20 visits per plan year. Preauthorization is required.
	Rehabilitation services	\$50 copay	Not covered	Combined limit of 12 visits per plan year with physical, speech, and occupational therapies.
	Habilitation services	\$50 copay	Not covered	
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- ACA Preventive care only

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 those agencies is: Department of Labor's Employee Benefits Security Administration at 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: Simplan at 800-680-0892 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? No

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 [800-680-0892]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800-680-0892]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[800-680-0892]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' [800-680-0892]

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 pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist [copayment]	\$50
■ Hospital (facility) [coinsurance]	\$350
■ Other [coinsurance]	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*)

Total Example Cost **\$13,254**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,490
The total Peg would pay is	\$3,790

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist [copayment]	\$50
■ Hospital (facility) [coinsurance]	\$350
■ Other [coinsurance]	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*)

Total Example Cost **\$8,017**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,050
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,052
The total Joe would pay is	\$7,102

Mia's Simple Fracture

(emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist [copayment]	\$50
■ Hospital (facility) [coinsurance]	\$350
■ Other [coinsurance]	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*)

Total Example Cost **\$2,520**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$810
The total Mia would pay is	\$2,110

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.