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: Personify Health at 800-849-0580. 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 or call 800-849-0580 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network $3,000/Self-only **Family Coverage** $3,400/Individual $6,000/Family	Out-of-Network $6,000/Self-only **Family Coverage** $6,600/Individual $12,000/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, 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.
	Network & Out-of-Network deductibles do not cross-apply		
Are there services covered before you meet your deductible?	**Yes,** preventive services.		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?	Network $7,100/ Self-only **Family Coverage** $7,100/Individual $14,200/Family	Out-of-Network $12,000/ Self-only **Family Coverage** $12,000/Individual $24,000/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 individual out-of-pocket limit until the overall family out-of-pocket limit has been met.
	Network & Out-of-Network out-of-pocket do not cross-apply		

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover and cost containment penalties for failure to obtain pre-authorization when required.	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.** See hcpdirectory.cigna.com or call 1-800-849-0580 for a list of 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
		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% coinsurance	40% coinsurance	Services may also be available through Teladoc. Call 1-800-Teladoc or visit www.teladoc.com Deductible waived for telemedicine visits with personal physicians & Teladoc visits.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Coinsurance eliminated with use of Quest facilities. Deductible will apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	US Imaging may be able to refer you to a facility. Coinsurance eliminated with use of these facilities. Deductible will apply. Contact US Imaging at 877-874-6385. Pre-authorization required for certain imaging. Benefit may be reduced if pre-authorization is not obtained.

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 More information about **prescription drug coverage** is available at www.customercare@rxbenefits.com	Generic drugs	20% coinsurance	Not covered	All retail & mail order prescription drugs must be obtained through a participating Express Scripts pharmacy. **Retail & Mail Order:** Up to 90-day supply
	Preferred brand drugs	20% coinsurance	Not covered	
	Non-preferred brand drugs	20% coinsurance	Not covered	
	Specialty drugs	20% coinsurance	Not covered	Must be obtained through Accredo. Call 800-922-8279.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-authorization required for certain procedures. Benefit may be reduced if pre-authorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	40% coinsurance	Coinsurance waived if seen in ER for same dx on same day. Contact Customer Service to initiate refund.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Limited to semi-private room rate. Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Services may also be available through Teladoc. Call 1-800-Teladoc or visit www.teladoc.com Deductible waived for telemedicine visits with personal providers & Teladoc visits. Pre-authorization required for certain services. Benefit may be reduced if pre-authorization is not obtained.
	Inpatient services	20% coinsurance	40% coinsurance	Limited to semi-private room rate. Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	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 are pregnant	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Pre-authorization is only required for stay exceeding 48 hours (or 96 hours after C-section.) When required, benefit may be reduced if pre-authorization is not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per Calendar Year. Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 60 visits per Calendar Year combined for Physical, Occupational and Speech therapy. Limits for habilitation services do not apply to autism spectrum disorders.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per Calendar Year. Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-authorization required for certain durable medical equipment. Benefit may be reduced if pre-authorization is not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Includes 10 days respite care.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Limited to one exam every three years.
	Children's glasses	Not covered		Must enroll in separate vision plan.
	Children's dental check-up	Not covered		Must enroll in separate dental plan.

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.)

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

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

- Acupuncture (Limited to 30 visits per Calendar Year)
- Bariatric surgery (Limited to treatment of morbid obesity)
- Chiropractic care (Limited to 30 visits per Calendar Year)
- Hearing aids (Limited to $4,000 every 36 months)
- Infertility treatment (Limited to $80,000 lifetime medical and Rx combined)
- Routine eye care (One exam every three years under age 40; one exam annually age 40 & over)
- Weight loss programs (Limited to treatment of morbid obesity)

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: Personify Health at 800-849-0580 and the Department of Labor, Employee Benefits Security Administration at 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 on how 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: Personify Health at 800-849-0580 and the Department of Labor, Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 800-849-0580.

*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** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (tests) 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 visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (brand name drugs) 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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **20%**
- **Hospital (ER) 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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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