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. You can view the Glossary at www.ccio.cms.gov or call 1-800-842-5899 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** person / **$1500** 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.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and Office Visits 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.
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?	**$3,000** person / **$6,000** family for medical expenses. There is also a **$3,500** family out-of-pocket for prescription drugs.	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 has been met.
What is not included in the out-of-pocket limit?	Deductibles, copayments, premiums, out-of-network services, balance billing charges, and health care that 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 network provider?	Yes. See www.cignasharedadministration.com or call (800) 768-4695 for a list of participating 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	$25 copayment; deductible waived	50% coinsurance within area (IA); 30% coinsurance out of area (OOA)	None
	Specialist visit	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Preventive care/screening/ immunization	No Charge	Not Covered	Hearing exams are not covered. Immunizations are covered as preventive only for children up to age 2.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	No Charge after $25 copayment if billed by PCP with Office Visit
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	20% coinsurance	Not Covered	Experimental Drugs, Smoking Deterrents, Erectile Dysfunction Drugs, and Substance Use Disorder Drugs Not Covered. If brand chosen when generic available, your cost will be your coinsurance payment plus the difference in retail cost between brand and generic.
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	20% coinsurance	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
If you need immediate medical attention	Emergency room care	$200 per occurrence; 20% coinsurance	$200 per occurrence; 50% coinsurance IA; 30% coinsurance OOA	Copayment waived if admitted within 48 hours.
	Emergency medical transportation	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	$200 limit per occurrence
	Urgent care	$25 copayment; deductible waived	$25 per occurrence; 50% coinsurance IA; 30% coinsurance OOA	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	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)	
	Physician/surgeon fees	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Substance Abuse Services Not Covered
	Inpatient services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Substance Abuse Services Not Covered
If you are pregnant	Office visits	$25 copayment; deductible waived	50% coinsurance IA; 30% coinsurance OOA	Not Covered for Dependent Children
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Not Covered for Dependent Children
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Not Covered for Dependent Children
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Limit 30 days per Calendar Year
	Rehabilitation services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Habilitation services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Skilled nursing care	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Durable medical equipment	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	None
	Hospice services	20% coinsurance	50% coinsurance IA; 30% coinsurance OOA	Routine Home Care (Days 1-60) - $193.03/day; Routine Home Care (Days 61+) - $151.61/day, Continuous Home Care (24 Hours) – $976.80/day; Inpatient Respite Care - $181.87/day; General Inpatient Care - $743.55/day
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to one exam per year
	Children's glasses	No Charge	No Charge	Limited to one pair of glasses per year
	Children's dental check-up	No Charge	No Charge	Semi-annual exams

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
- Experimental treatments
- Hearing exams/aids
- Infertility treatment
- Long-term care
- Substance use disorder services (inpatient and outpatient)
- Maternity benefits (not covered for dependent children)
- Non-emergency care when traveling outside of the U.S.
- 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.)

- Chiropractic care
- Private duty nursing
- Routine dental care (Adult)
- Routine eye care (Adult)

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: 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 (800) 842-5899.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 842-5899.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** (800) 842-5899.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 842-5899.]

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	$750
Specialist *coinsurance*	20%
Hospital (facility) coinsurance	20%
Other *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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,414
What isn't covered	
Limits or exclusions	$97
The total Peg would pay is	**$3,261**

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

The plan's overall deductible	$750
Specialist *coinsurance*	20%
Hospital (facility) coinsurance	20%
Other *copayments*	$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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$1,185
What isn't covered	
Limits or exclusions	$205
The total Joe would pay is	**$2,240**

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

The plan's overall deductible	$750
Specialist *coinsurance*	20%
Hospital (facility) coinsurance	20%
Other *copayment*	$200

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$116
What isn't covered	
Limits or exclusions	$392
The total Mia would pay is	**$1,459**

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