

 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 visit the website: [www.myCigna.com](http://www.myCigna.com). 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf> or call 1-888-201-1964 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> : \$1,500 / individual or \$3,000 / family <a href="#">Out of Network</a> : \$5,000 / individual or \$10,000 / family	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive Care</a> , is 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> .
Are there other <a href="#">deductibles</a> for specific services?	No	There are no other <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network</a> : \$4,000 / individual or \$8,000 / family <a href="#">Out of Network</a> : \$10,000 / individual or \$20,000 / 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. <a href="#">Preauthorization</a> penalties, and charges that exceed eligible expenses	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 888-219-5122 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You may see any <a href="#">specialist</a> 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 <a href="#">provider's</a> office or clinic	Primary Care Services – Preventive care/Screenings/Immunizations	\$0 Copay	Not covered	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.
	Virtual Primary Care Services (via Recuro Network) - Preventive care/Screenings - Adults 18 yrs +	\$0 Copay	Not Covered	
	Primary Care Services - Other / Ongoing Care	\$30 Copay	50% after deductible	
	Virtual Primary Care Services (via Recuro Network) – Other / Ongoing Care	\$0 Copay	Not Covered	
	<a href="#">Specialist</a> visit	\$45 Copay	50% after deductible	
If you have a test	Advanced Imaging	CT Scan, Pet Scan, MRI: \$0 copay after deductible if member coordinates services through Concierge, otherwise services are subject to \$100 copay (ded. waived) at an independent facility, or \$100 copay after deductible in a hospital setting. Other Advanced Imaging Services: \$100 copay (ded. waived) at an independent facility, or \$100 copay after deductible in a hospital setting.	50% after deductible	Call required to Concierge
	Non-Advanced Imaging (general x-ray)	\$10 copay	50% after deductible	Call required to Concierge
	Lab	No Charge	50% after deductible	Call required to Concierge
		\$10 <a href="#">copay</a> (retail)	50% 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)	
If you need drugs to treat your illness or condition	Preferred Generic drugs (Tier 1)	\$20 <a href="#">copay</a> (mail order)	Not Covered	Covers up to a 30-day supply (retail Prescription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2) & High-Cost Generic	\$40 <a href="#">copay</a> (retail)	50% after deductible	
		\$80 <a href="#">copay</a> (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3) & Non-Formulary	30% up to \$500/script (retail)	50% after deductible	
		30% up to \$1,000/script (mail order)	Not Covered	
	Specialty drugs (Tier 4)	30% up to \$750/script (retail)	50% after deductible	
30% up to \$1,500/script (mail order)		Not Covered		
If you have outpatient surgery	Office Setting	\$500 copay (deductible waived)	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	Independent facility	\$500 copay (deductible waived)	50% after <a href="#">deductible</a>	
	Hospital setting	\$500 copay after deductible	50% after <a href="#">deductible</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	INN: \$350 Copay OON: Same as in-network benefit: \$350 Copay		
	<a href="#">Emergency medical transportation</a>	INN: \$200 Copay OON: Same as in-network benefit: \$200 Copay		
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a>	Same as in-network benefit: \$75 copay	

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)	
	Virtual Urgent Care - via Recuro Network	\$0 copay (deductible waived)	Same as in-network benefit: \$0 copay (deductible waived)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/day; \$2,500 copay/max. per admission after deductible	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	Physician/surgeon fees	\$500 copay/day; \$2,500 copay/max. per admission after deductible	50% after <a href="#">deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient Behavioral Health	Covered same as any medical outpatient service. \$45 copay	50% after <a href="#">deductible</a>	Call required to Concierge
	Virtual Outpatient Behavioral Health - via Recuro network	Counseling/Therapist: \$0 copay, deductible waived; Psychiatrist: \$50 copay, deductible waived	Not covered	Call required to Concierge
	Inpatient services	Covered same as any medical inpatient service. \$500 copay/day; \$2,500 copay/max. per admission after deductible	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
If you are pregnant	Office visits	Initial visit: \$45 copay; After pregnancy is confirmed, office visits covered in full. *Baby not charged separate deductible. Baby covered under Mom until discharged, unless baby remains in hospital after Mom discharged.	50% after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound). <a href="#">Preauthorization</a> required for hospital stays longer than 48 hours of normal vaginal deliver or 96 hours for cesarean section delivery
	Childbirth/delivery professional services	\$500 copay/day; \$2,500 copay max. per admission after deductible	50% after <a href="#">deductible</a>	
	Childbirth/delivery facility services	\$500 copay/day; \$2,500 copay max. per admission after deductible	50% after <a href="#">deductible</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	Home health care (100 visits per year)	\$45 copay after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	<a href="#">Rehabilitation services</a>	\$45 copay/visit (deductible waived). 40 visits per member per benefit year, combined for PT, OT & Speech.	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	<a href="#">Habilitation services</a>	\$45 copay/visit (deductible waived).	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	<a href="#">Skilled nursing care</a>	\$500 copay/day; \$2,500 copay max. per admission after deductible, limited to 90 days per plan year.	50% after ded., limited to 90 days per plan year.	<a href="#">Preauthorization</a> required or benefits may be reduced.
	<a href="#">Durable medical equipment</a>	30% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
	<a href="#">Hospice services</a>	\$500 copay/day; \$2,500 copay max. per admission after deductible	50% after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required or benefits may be reduced.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not covered except services listed under the ACA guidelines (Network)
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	Not covered except services listed under the ACA guidelines (Network)

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Allergy Services</li> <li>Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing Exam</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> </ul>

**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](http://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](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 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: contact the plan at 1-541-664-1261. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). "Additionally, a consumer assistance program can help you file your appeal. Contact ." A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**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 - 888-219-5122

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa - 888-219-5122

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 - 888-219-5122

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' - 888-219-5122

*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 [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$45
<a href="#">Coinsurance</a>	0%
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Peg would pay is</b>	

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay: \$

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$45
<a href="#">Coinsurance</a>	0%
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Joe would pay is</b>	

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$45
- Hospital (facility) [coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay: \$

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$45
<a href="#">Coinsurance</a>	0%
<i>What isn't covered</i>	
Limits or exclusions	
<b>The total Mia would pay is</b>	