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. 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 deductible?	Network: $3,000 / individual or $6,000 / family Out of Network: $7,000 / individual or $14,000 / 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.
Are there services covered before you meet your deductible?	Yes. Preventive Care, is 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	There are no other deductibles.
What is the out-of-pocket limit for this plan?	Network: $6,000 / individual or $12,000 / family Out of Network: $15,800 / individual or $31,600 / 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, balance-billing charges, and health care this plan doesn't cover. Preauthorization penalties, and charges that exceed eligible expenses	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.myCigna.com or call 888-219-5122 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You may see any specialist 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 Services – Preventive care/Screenings/Immunizations	$0 Copay	Not covered	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.
	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	
	Specialist 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 10% after deductible. Other Advanced Imaging Services: 10% after deductible.	50% after deductible	Call Required to Concierge
	Non-Advanced Imaging (general x-ray)	$40 copay after deductible	50% after deductible	Call Required to Concierge
	Lab	$10 copay after deductible	50% after deductible	Call Required to Concierge

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)	$10 copay (retail)	50% after deductible	Covers up to a 30-day supply (retail Prescription); 31-90-day supply (mail order prescription).
		$20 copay (mail order)	Not Covered	
	Preferred brand drugs (Tier 2) & High-Cost Generic	$40 copay (retail)	50% after deductible	
		$80 copay (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 deductible	
	Independent facility	$500 copay (deductible waived)	50% after deductible	Preauthorization required or benefits may be reduced.
	Hospital setting	10% after deductible	50% after deductible	Preauthorization required or benefits may be reduced.
	Emergency room care	INN: $350 Copay OON: Same as in-network benefit: $350 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)	
If you need immediate medical attention	Emergency medical transportation	INN: $200 Copay OON: Same as in-network benefit: $200 Copay		
	Urgent care	$75 copay	Same as in-network benefit: $75 copay	
	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)	10% after deductible	50% after deductible	Preauthorization required or benefits may be reduced.
	Physician/surgeon fees	10% after deductible	50% after deductible	
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 deductible	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. 10% after deductible.	50% after deductible	Preauthorization 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 deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e.ultrasound). Preauthorization required for hospital stays longer than 48 hours of normal vaginal deliver or 96 hours for cesarean section delivery
	Childbirth/delivery professional services	10% after deductible	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)	
	Childbirth/delivery facility services	10% after deductible	50% after deductible	
If you need help recovering or have other special health needs	Home health care (100 visits per year)	10% after deductible	50% after deductible	Preauthorization required or benefits may be reduced.
	Rehabilitation services	$45 copay/visit (deductible waived). 40 visits per member per benefit year, combined for PT, OT & Speech.	50% after deductible	Preauthorization required or benefits may be reduced.
	Habilitation services	$45 copay/visit (deductible waived).	50% after deductible	Preauthorization required or benefits may be reduced.
	Skilled nursing care	10% after deductible, limited to 90 days per plan year.	50% after ded., limited to 90 days per plan year.	Preauthorization required or benefits may be reduced.
	Durable medical equipment	30% after deductible	50% after deductible	
	Hospice services	10% after deductible	50% after deductible	Preauthorization required or benefits may be reduced.
If your child needs dental or eye care	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside 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.)

- Allergy Services
- Routine eye care (Adult)
- Chiropractic care
- Hearing Exam
- Private-duty nursing

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 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. "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, kwiijigo holne' - 888-219-5122

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 copayment** **$45**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$45
Coinsurance	10%
What isn't covered	
Limits or exclusions	
The total Peg would pay is	

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 copayment** **$45**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$45
Coinsurance	10%
What isn't covered	
Limits or exclusions	
The total Joe would pay is	

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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*	$3,000
Copayments	$45
Coinsurance	10%
What isn't covered	
Limits or exclusions	
The total Mia would pay is	