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, contact 1-866-662-2537. 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.healthcare.gov/sbc-glossary.com or call 1-866-662-2537 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/individual.	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 amount before this plan begins to pay. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Network preventive care and COVID-19 vaccinations 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 http://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	Medical: in-**network $5,000/** Individual; **$10,000**/ Family Rx (in-**network**): **$1,850**/ Individual, **$3,700**/ 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, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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. For network medical providers see www.mycigna.com or call 1-800-768-4695	This plan uses a provider network. If you use an in-network doctor or health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network provider might use an out-of-network provider for some services. 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	30% coinsurance up to Cigna allowed amount.	Not covered	None.
	Specialist visit	30% coinsurance up to Cigna allowed amount.	Not covered	
	Preventive care/screening/ Immunization	No charge deductible does not apply.	Not covered	Age and frequency limits apply as permitted by the Affordable Care Act (ACA). Ask your provider if the services needed are preventive. Then check to see what your plan covers.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance up to Cigna allowed amount.	Not covered	Diagnostic tests must be provided by Quest or LabCorp, unless provided by an out-of-network provider at an in-network facility
	Imaging (CT/PET scans, MRIs)	30% coinsurance up to Cigna allowed amount.	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	5% copay, $5 minimum	Not covered	Deductible does not apply. Limited up to 30-day supply; 90-day supply for 3 copays at Participating Pharmacies Up to 90 day supply for 2 copays through Mail Order. Certain drugs have other dispensing limits. If you request a brand name drug when a generic equivalent is available, you must also pay the difference in cost between the generic drug and brand name drug in addition to the copay. Certain prescription drugs require preauthorization or no benefits are provided.
	Preferred brand drugs	15% copay, $15 minimum	Not covered	
	Non-preferred brand drugs	25% copay, $25 minimum	Not covered	
	Specialty drugs	Applicable Generic, Preferred and Non-Preferred copays.	Not covered	You must contact BriovaRx at (855) 427-4682 for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	Limited to 1 visit/day same physician or surgeon, no coverage for pre/post-op charges from physician performing procedure.

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 room care	$75 facility fee copay, then 30% coinsurance.	$75 facility fee copay, then 30% coinsurance	$75 **copay** will be waived if admitted to hospital the same day emergency room charges are incurred.
	Emergency medical transportation	30% coinsurance.	30% coinsurance	No coverage for ambulance transport between facilities in non-emergency situations
	Urgent care	30% coinsurance.	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance.	Not covered	**Preauthorization** by CareAllies 1-800-768-4695 required before admission, or 48 hours after an emergency, or the payment will be reduced to 20% up to $1,000 maximum.
	Physician/surgeon fees	30% coinsurance.	Not covered	Limited to 1 visit/day same physician or surgeon, no coverage for pre/post-op charges from physician performing procedure.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance.	Not covered	None.
	Inpatient services	30% coinsurance.	Not covered	**Preauthorization** by CareAllies 1-800-768-4695 required before admission, or 48 hours after an emergency, or the payment will be reduced to 20% up to $1,000 maximum. 70 day maximum stay.
If you are pregnant	Office visits	30% coinsurance.	Not covered	Cost sharing does not apply for ACA required preventive screenings. Depending on the type of services, coinsurance and/or a deductible may apply.
	Childbirth/delivery professional services	30% coinsurance.	Not covered	None.
	Childbirth/delivery facility services	30% coinsurance.	Not covered	**Preauthorization** by CareAllies 1-800-768-4695 required before admission, or 48 hours after an emergency, or the payment will be reduced to 20% up to $1,000 maximum
If you need help recovering or have	Home health care	30% coinsurance	Not covered	Preauthorization by CareAllies 1-800-768-4695 required before admission.

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)	
other special health needs	Rehabilitation services	30% coinsurance.	Not covered	Inpatient rehabilitation: Preauthorization by CareAllies 1-800-768-4695 required before admission
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	30% coinsurance.	Not covered	No coverage if more than 30 days between hospital discharge and admission.
	Durable medical equipment	30% coinsurance.	Not covered	Fund reserves right to purchase rather than rent some durable medical equipment to control costs.
	Hospice services	30% coinsurance.	Not covered	Preauthorization by CareAllies 1-800-768-4695 required before admission.
If your child needs dental or eye care	Children's eye exam	No charge.	You pay up front and seek reimbursement from Group Vision Services.	Limited to one exam every 24 months; out of network up to $32/exam maximum reimbursement provided through Group Vision Services.
	Children's glasses	No charge.		
	Children's dental check-up	No charge	Not covered	Limited to one exam every 6 months.

* To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply.

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
- Dental Care (separate plan)
- Habilitation services
- Infertility treatment
- Long-term care
- Weight loss programs
- Routine foot care

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

- Hearing aids (If hearing losse is due to non-occupational injury only)
- Chiropractic care (Up to plan Limits)
- Cosmetic surgery (Limited to reconstructive surgery following mastectomy or resulting for non-occupational injury)
- Private duty nursing (Out-patient only)
- Routine eye care (to plan limits)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-866-662-2537. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 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 the plan at 1-866-662-2537. For more information about your rights, this notice, or assistance, contact the plan at 443-573-3632 or 1-866-621-7974. You may also contact the U.S. Department of Labor, Benefits Security Administration (1-866-444-3272 or www.dol.gov/ebsa) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or www.cciio.cms.gov)

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 (Espanol): Para obtener asistencia en Espanol, llame at 1/800-638-2972

*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	$500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$500
Copayments	$0
Coinsurance	$3,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

The plan's overall deductible	$500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$500
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$500
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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