



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 us. 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.healthcare.gov/sbc-glossary> or call 1-888-292-0272 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	For <u>network providers</u> \$3,500 person/\$7,000 family; For <u>out-of-network providers</u> \$7,000 person/\$14,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For <u>network providers</u> \$7,150 individual/\$14,300 family; for <u>out-of-network providers</u> \$21,450 person / \$42,900 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed</u> charges, penalty for not obtaining <u>Preauthorization</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See ASAlookup.AetnaSignatureAdministrators.com for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	\$35 <u>copay</u> /visit, then covered at 100%	50% <u>coinsurance</u>	<u>Copayment</u> is not subject to any <u>Deductible</u> . <u>Copay</u> applies to exam charge only. Does not include office surgery. Limited to General Practice, Obstetrics/Gynecology, Internal Medicine, Osteopaths, Mental Health Providers and Pediatricians. See <u>Plan Document</u> for other services.
	<u>Specialist visit</u>	\$50 <u>copay</u> /visit, then covered at 100%	50% <u>coinsurance</u>	<u>Copay</u> applies to exam charge only. See <u>Plan Document</u> for other services.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	As required under the ACA, <u>cost sharing</u> does not apply to identified clinical <u>preventive services</u> . Any other preventive medicine services covered under your <u>plan</u> are subject to <u>deductible</u> and <u>coinsurance</u> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs	\$20 <u>copay</u> retail/\$60 <u>copay</u> mail order	50% <u>coinsurance</u> retail/Not covered mail order	When the retail store offers a lower price for generic, pay only the lower price. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$50 <u>copay</u> retail/\$150 <u>copay</u> mail order	50% <u>coinsurance</u> retail/Not covered mail order	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs	\$75 <u>copay</u> retail/\$225 <u>copay</u> mail order	50% <u>coinsurance</u> retail/Not covered mail order	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

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)	
	<u>Specialty drugs</u>	30% <u>coinsurance</u>	Not covered	To receive the <u>network provider</u> benefit, you must obtain <u>specialty drugs</u> from a specialty pharmacy <u>provider</u> as designated by us. Call 1-800-325-1404 for further information. <u>Specialty drugs</u> obtained from a non-designated specialty pharmacy <u>provider</u> will not be covered. Authorization is required. Benefits will not be paid for any <u>specialty drugs</u> that are not authorized by the Medical Review Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergency use will result in a reduction of charges up to the <u>preauthorization</u> penalty amount. The penalty is not covered.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	To the nearest Acute Medical Facility that can treat the sickness or injury.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, then covered at 100%	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	Limited to 40 visits per year.
	Inpatient services	50% <u>coinsurance</u>	70% <u>coinsurance</u>	<u>Preauthorization</u> is required. If not received, a penalty will be applied. Limited to 30 days per year.

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	Office visits	\$50 copay/visit, then covered at 100%	50% coinsurance	Copay applies to exam charge only. See <u>Plan</u> Document for other services.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	<u>Home health care</u>	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required. If not received, a penalty will be applied. Limited to 30 visits per year.
	<u>Rehabilitation services</u>	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required for Inpatient. If not received, a penalty will be applied. Inpatient limited to 31 days per year. Outpatient limited to 30 visits per year.
	<u>Habilitation services</u>	30% coinsurance	50% coinsurance	
	<u>Skilled nursing care</u>	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required. If not received, a penalty will be applied.
	<u>Durable medical equipment</u>	30% coinsurance	50% coinsurance	<u>Preauthorization</u> is required for amounts greater than \$1,500. If not received, a penalty will be applied.
	<u>Hospice services</u>	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental checkup	Not covered	Not covered	None

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
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult), except for treatment of diabetes
- Routine foot care, except for treatment of diabetes
- 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

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: contact the plan at 1-888-292-0272, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA 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 Standard? 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 866-387-0489.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-387-0489.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-387-0489

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-387-0489.

-----*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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$100
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,360

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copayment</u>	\$50
■ <u>Hospital (facility) coinsurance</u>	30%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,355

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Emergency room coinsurance</u>	30%
■ <u>Hospital (facility) coinsurance</u>	30%
■ Other <u>coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,600
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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