**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 at www.alliedbenefit.com or call 1-888-306-0905. 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 1-888-306-0905 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,000 individual/$6,000 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 and primary care services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **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?** | $7,150 individual/$14,300 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, penalty for not obtaining Preauthorization and health care 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 participating provider?** | Not applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit, then covered at 100% | Copayment is not subject to any Deductible. Copay applies to exam charge only. Does not include office surgery. |
| | Specialist visit | $35 copay/visit, then covered at 100% | Copayment is not subject to any Deductible. Copay applies to exam charge only. See Plan Document for other services. |
| | Preventive care/ screening/ immunization | No charge. Deductible does not apply. | As required under the Affordable Care Act(ACA), cost sharing does not apply to identified clinical preventive services. Any other preventive medicine services covered under your plan are subject to deductible and coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Covered at 100% after deductible is met. | Inpatient services are subject to deductible. Deductible is waived for covered charges for outpatient services. |
| | Imaging (CT/PET scans, MRIs) | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions & Other Important Information |
|---|---|---|---|
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.myCigna.com | Generic drugs (Tier 1) | $0 copay retail/$0 copay 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 (Tier 2) | $35 copay retail/$105 copay 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 (Tier 3) | $50 copay retail/$150 copay 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). |
| | Specialty drugs (Tier 4) | Not covered | Call 1-888-306-0905 for further information. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |
| | Physician/surgeon fees | Covered at 100% after deductible is met. | |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions & Other Important Information |
|---|---|---|---|
| **If you need immediate medical attention** | Emergency room care | $250 access fee followed by deductible | Non-emergency use will result in a reduction of charges up to the preauthorization penalty amount. The penalty is not covered. |
| | Emergency medical transportation | Covered at 100% after deductible is met. | To the nearest Acute Medical Facility that can treat the sickness or injury. |
| | Urgent care | $75 copay/visit, then covered at 100% | Copayment is not subject to any Deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |
| | Physician/surgeon fees | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/visit, then covered at 100%. | Copayments apply to the office visit charge only. Any other services covered under your plan are subject to deductible and coinsurance. |
| | Inpatient services | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions & Other Important Information |
|---|---|---|---|
| **If you are pregnant** | Office visits | $35 copay/visit, then covered at 100% | Copayment is not subject to any Deductible. Copay applies to exam charge only. See Plan Document for other services. |
| | Childbirth/delivery professional services | Covered at 100% after deductible is met. | None |
| | Childbirth/delivery facility services | Covered at 100% after deductible is met. | None |
| **If you need help recovering or have other special health needs** | Home health care | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. Limited to 60 visits per year. |
| | Rehabilitation services | Covered at 100% after deductible is met. | Preauthorization 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. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions & Other Important Information |
|---|---|---|---|
| | Habilitation services | Covered at 100% after deductible is met. | Preauthorization 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. |
| | Skilled nursing care | Covered at 100% after deductible is met. | Preauthorization is required. If not received, a penalty will be applied. |
| | Durable medical equipment | Covered at 100% after deductible is met. | Preauthorization is required for amounts greater than $1,500. If not received, a penalty will be applied. |
| | Hospice services | Covered at 100% after deductible is met. | None |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | None |
| | Children's glasses | Not covered | None |
| | Children's dental checkup | 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
- 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
- Infertility treatment

**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 1-888-306-0905 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) 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 1-888-306-0905 or 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.**
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 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 1-888-306-0905.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-306-0905.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-306-0905.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-306-0905.

*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 | $3,000 |
| Specialist copayment | $35 |
| 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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $1,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,560** |

### 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 | $35 |
| 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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,620** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,100 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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