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, call 770-997-9910 or toll-free at 800-241-2136. 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:/healthcare.gov/sbc-glossary or call 770-997-9910 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600**/individual or **$1,200**/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 services, network provider primary care office visits, network provider urgent care visits, prescription drugs, preventive dental services, and vision 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?	Yes. **$125** per visit for emergency room care; Dental services - **$50**/individual or **$150**/family. There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,000**/individual; **$13,000**/family Prescription drugs **$3,100**/individual, **$6,200**/family Non-Network: unlimited	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, penalties for failure to obtain preauthorization, dental or vision services (except those covered under major medical), 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 network provider?	Yes. For a list of participating providers, see www.myCigna.com or call 1-800-CIGNA24	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 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)	Non-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 copay/visit. Deductible does not apply.	50% coinsurance	Treatment of TMJ is limited to $750/year for non-surgical treatment, $2,000/year for surgical treatment, and $2,000/lifetime combined. Treatment of Obstructive Sleep Apnea is limited to $5,000/year and $10,000/lifetime.
	Specialist visit	15% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	Not covered	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)	15% coinsurance	50% coinsurance	Preauthorization is required for certain services. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance. Certain services received from non-network providers while at an in-network facility may be covered as in-network.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail-30: Greater of $10 copay/script or 10% coinsurance, not to exceed $20 Retail-90: Greater of $28 copay/script or 10% coinsurance, not to exceed $56 Home Delivery: Greater of $25 copay/script or	Retail-30: Greater of $10 copay/script or 10% coinsurance, not to exceed $20 Retail-90 and Home Delivery: Not covered	Deductible does not apply. Coverage is limited to 30-day supply for specialty drugs, 34-days supply for non-maintenance drugs and 90-day supply for maintenance drugs. Coverage for Home Delivery is limited to maintenance medications only. If brand name drug is requested when there is

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		10% coinsurance, not to exceed $40		an equivalent generic alternative, you will be required to pay the difference in cost between the brand name and generic. Coverage for certain medications may be subject to step therapy, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered. Specialty drugs must be obtained through the Optum Specialty Pharmacy.
	Preferred brand drugs	Retail-30: Greater of $20 copay/script or 20% coinsurance, not to exceed $50 Retail-90: Greater of $42 copay/script or 15% coinsurance, not to exceed $140 Home Delivery: Greater of $50 copay/script or 15% coinsurance, not to exceed $100	Retail-30: Greater of $20 copay/script or 20% coinsurance, not to exceed $50 Retail-90 and Home Delivery: Not covered	
	Non-preferred brand drugs	Retail-30: Greater of $35 copay/script or 30% coinsurance, not to exceed $75 Retail-90: Greater of $70 copay/script or 10% coinsurance, not to exceed $210 Home Delivery: Greater of $75 copay/script or 25% coinsurance, not to exceed $150	Retail-30: Greater of $35 copay/script or 30% coinsurance, not to exceed $75 Retail-90 and Home Delivery: Not covered	
	Biosimilar Specialty drugs	Lesser of $100 copay/ script or 8% coinsurance	Not covered	
	Preferred Specialty drugs	Lesser of $250 copay/ script or 15% coinsurance	Not covered	
	Non-Preferred Specialty drugs	Lesser of $400 copay/ script or 25% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	Preauthorization is required. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance. Treatment of TMJ is limited to $750/year for non-surgical treatment, $2,000/year for surgical treatment, and $2,000/lifetime combined. Treatment of Obstructive Sleep Apnea is limited to $5,000/year and $10,000/lifetime. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$125/visit then 15% coinsurance	Covered as In-Network	If admitted to the hospital, the $125 deductible is waived.
	Emergency medical transportation	15% coinsurance	Covered as In-Network	None
	Urgent care	$35 copay/visit. Deductible does not apply.	50% coinsurance	Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	Preauthorization is required If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance. For Organ Transplant Benefits, the facility must be designated as an in-network Center of Excellence (COE). If COE is not used, you will pay 40% coinsurance for facility and professional charges both in-network and non-network. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	50% coinsurance	Preauthorization is required for inpatient services and certain outpatient services. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance. Treatment of substance abuse disorders is not covered.
	Inpatient services	15% coinsurance	50% coinsurance	
If you are pregnant	Office visits	15% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for dependent child pregnancy, except for certain preventive services. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Childbirth/delivery professional services	15% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	Preauthorization is required. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance.
	Rehabilitation services	15% coinsurance	50% coinsurance	None
	Habilitation services	15% coinsurance	50% coinsurance	None
	Skilled nursing care	15% coinsurance	50% coinsurance	Preauthorization is required. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance.
	Durable medical equipment	15% coinsurance	50% coinsurance	Preauthorization is required. If you fail to obtain preauthorization for services provided by non-network providers, you will be required to pay an extra 10% coinsurance. Treatment of Obstructive Sleep Apnea is limited to $5,000/year and $10,000/lifetime.
	Hospice services	15% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	All charges in excess of $45. Deductible does not apply.	Limited to one exam/year. Not included in out-of-pocket limit.
	Children's glasses	No Charge. Deductible does not apply.	All charges in excess of $35-$75 (depending on lens type); $60 (frames). Deductible does not apply.	Limited to 1 set of glasses/year. Additional charges will apply for frames purchased from a network provider over $135 retail value or special coatings/tints to lenses. Not included in out-of-pocket limit.
	Children's dental check-up	No Charge. Deductible does not apply.	All charges over UCR. Deductible does not apply.	Limited to one exams/six months and $1,500 annual maximum. Not included in out-of-pocket limit.

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, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pregnancy of a dependent child, except for mandated preventive services
- Substance abuse services
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Dental care (adult), limited to $1,500 annual maximum
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot 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: the 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 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 770-997-9910 or toll-free at 1-800-241-2136 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For insured dental and vision benefits, you can contact your State Department of Insurance. In Georgia, contact the Georgia Office of Insurance and Safety Fire Commissioner at 1-800-656-2298 or www.oci.ga.gov/consumerservice/home.aspx. In Alabama, contact the Alabama Department of Insurance at 334-241-4141 or www.aldoi.gov/ContactUs.aspx.

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 1-866-533-5011 PIN 4360.

*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	$600
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$600
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,470**

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

The plan's overall deductible	$600
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$300
Copayments	$700
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	$600
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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*	$725
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,035**

* This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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