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, https://portal.employeeplansllc.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.healthcare.gov/sbc-glossary or call 1-800-964-7444 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Preferred Providers, PPO, (In-Network)** **$1000 single / $3000 family** **Non-preferred Providers, Non-PPO, (Out of Network)** **$2000 single / $6000 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, physician services, emergency room services, allergy injections, chiropractic care, urgent care visits, and therapies: physical, speech and occupational.**	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, $250 for prescription drug coverage per person, per calendar year.**	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?	**Preferred providers** **$4000 single / $ 8000 family** **Non-preferred providers** **$8000 single / $ 16,000 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 healthcare this plan does not cover, charges not authorized by a Utilization Review Program, and prescription drug copayments.**	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 https://www.cigna.com or call (800) 964-7444 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 a non-preferred 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 a non-preferred provider for some services (such as lab work). 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$20 copay/ visit; deductible does not apply	40% coinsurance	Office Visit Includes: diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum and allergy injections.
	Specialist visit	$20 copay/ visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention, preventive care and screenings recommended by the Health Resources and Services Administration.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	* Included under office visit copay when service is done at a preferred provider's office.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay per prescription retail; $15 copay per prescription mail	Not covered	Limited to: 30 day supply retail prescription 90 day supply mail order prescription Maximum out-of-pocket at a preferred provider Single $2,600 / Family $5,200
	Preferred brand drugs	$45 copay per prescription retail; $115 copay per prescription mail	Not covered	
	Non-preferred brand drugs	$75 copay per prescription retail; $225 copay per prescription mail	Not covered	
	Specialty drugs	25% coinsurance per prescription Up to $200 per fill	Not Covered	Limited to: 30 day supply Maximum out-of-pocket at a preferred provider Single $2,600 / Family $5,200
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---------- None ----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---------- None ----------
If you need immediate medical attention	Emergency room care	$250 copay; 20% coinsurance		Includes all related expenses.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary.
	Urgent care	$75 copay/office visit; deductible does not apply	40% coinsurance	Includes all related expenses.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document
	Physician/surgeon fees	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; deductible does not apply Other outpatient - 20% coinsurance	40% coinsurance	Office Visit Includes: diagnostic testing (except MRI, CT & PET scans) and injections
	Inpatient services	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Charges for Office visits are considered under the global delivery fee. Cost sharing does not apply for preventive services. 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. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per calendar year
	Rehabilitation services	Physical, Speech and Occupational therapy – $20 copay/visit deductible does not apply all others 20% coinsurance	40% coinsurance	Must be medically necessary. Physical, Speech, Occupational, and Pulmonary Rehabilitation are limited to 20 visits per calendar year, Cardiac Rehabilitation is 36 visits per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	Limitations may apply based on the type of service rendered. Refer to your plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---------- None ----------
	Hospice services	20% coinsurance	40% coinsurance	---------- None ----------
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	---------- None ----------
	Children's glasses	Not Covered	Not Covered	---------- None ----------
	Children's dental check-up	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
- Convalescent Care
- Cosmetic Surgery
- Dental Care (Adult)
- Experimental/ Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Routine Eye care (Adult)
- Routine Foot Care
- Sex Transformation or sexual dysfunctions

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

- Chiropractic Care-limited to 12 visits per calendar year
- Private Duty Nursing-limited to 82 visits per calendar year and 164 visits per lifetime
- Weight Loss Programs-individual's weight must be in excess of 170% of standard weight tables

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, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, Employee Plans LLC 1-800-964-7444.. 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: Employee Plans LLC, 1111 Chestnut Hills Parkway, Fort Wayne, Indiana 46814, 1-800-964-7444, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to http://www.in.gov/idoi/2547.htm#2.

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 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.

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** **$1000**
- **Specialist *copayment*** **$20**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$1000
Copayments	$0
Coinsurance	$2300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,300**

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

- **The plan's overall deductible** **$1000**
- **Specialist *copayment*** **$20**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$400
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$1000**
- **Specialist *copayment*** **$20**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$1000
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Preferred Provider, PPO, (In-Network)** **$2000/single or $6000/family** **Non-Preferred Provider, Non-PPO, (Out of Network)** **$4000/single or $12,000/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, physician services, emergency room services, allergy injections, chiropractic care, urgent care visits, and therapies: physical, speech and occupational.**	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, $250 for prescription drug coverage per person, per calendar year.**	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?	**For Preferred Providers** **$5000 single/$10,000 family** **For Non-Preferred Providers** **$10,000 single/$20,000 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?	**Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges and prescription drug cost healthcare this plan does not 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, See https://www.cigna.com or call (800) 964-7444 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 a non-preferred 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 a non-preferred provider for some services (such as lab work). 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$25 copay/visit; deductible does not apply	40% coinsurance	Office Visit Includes: diagnostic testing (except MRI, CT & PET scans), injections, and surgery. 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.
	Specialist visit	$25 copay/visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	* Included under office visit copay when service is done at a preferred provider's office.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------None----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$15 copay per prescription retail; $15 copay per prescription mail	Not covered	Limited to: 30 day supply retail prescription 90 day supply mail order prescription Maximum out-of-pocket at a preferred provider Single $1,600 / Family $3,200
	Preferred brand drugs	$45 copay per prescription retail; $115 copay per prescription mail	Not covered	
	Non-preferred brand drugs	$75 copay per prescription retail; $225 copay per prescription mail		
	Specialty drugs	25% coinsurance up to $200 per fill	Not Covered	Limited to: 30 day supply Maximum out-of-pocket at a preferred provider Single $1,600 / Family $3,200

* For more information about limitations and exceptions, see the plan or policy document at https://portal.employeeplansllc.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---------- None ----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.
If you need immediate medical attention	Emergency room care	$250 copay; 20% coinsurance; deductible does not apply		Includes all related expenses.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary.
	Urgent care	$75 copay/visit; deductible does not apply	40% coinsurance	Includes all related expenses.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document
	Physician/surgeon fees	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply Other outpatient - 20% coinsurance	40% coinsurance	Office Visit Includes: diagnostic testing (except MRI, CT & PET scans) and injections
	Inpatient services	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Charges for Office visits are considered under the global delivery fee. Cost sharing does not apply for preventive services. 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. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per calendar year
	Rehabilitation services	Physical, Speech and Occupational therapies – $25 copay/visit, deductible does not apply All others – 20% coinsurance	40% coinsurance	Must be medically necessary. Occupational, Physical, Speech, and Pulmonary, Rehabilitation are limited to 20 visits per calendar year. Cardiac Rehab-limited to 36 visits per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	Limitations may apply based on the type of service rendered. Refer to your plan document.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---------- None ----------
	Hospice services	20% coinsurance	40% coinsurance	---------- None ----------
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	---------- None ----------
	Children's glasses	Not Covered	Not Covered	---------- None ----------
	Children's dental check-up	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)
- Experimental/ Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Routine Eye care (Adult)
- Routine Foot Care
- Sex Transformation or sexual dysfunctions

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

- Chiropractic Care-limited to 12 visits per calendar year
- Private Duty Nursing-limited to 82 visits per calendar year and 164 visits per lifetime.
- Weight Loss Programs-individual's weight must be in excess of 170% of standard weight tables

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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to http://www.in.gov/idoi/2547.htm#2.

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 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.

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

* For more information about limitations and exceptions, see the plan or policy document at https://portal.employeeplansllc.com

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** **$2000**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$2000
Copayments	$10
Coinsurance	$2100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,100**

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

- **The plan's overall deductible** **$2000**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$400
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$2000**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy copayment*** **$15/$45**

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	$2000
Copayments	$10
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

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, https://portal.employeeplansllc.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.healthcare.gov/sbc-glossary or call 1-800-964-7444 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Preferred Provider, PPO, (In-Network)** **$3000/single or $9000/family** **Non-Preferred Provider, Non-PPO, (Out of Network)** **$6000/single or $18,000/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**	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 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?	**For Preferred Providers** **$6,550 single/$13,100 family** **For Non-Preferred Providers** **$12,000 single/$36,000 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?	**Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, health care this plan does not 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, See https://www.cigna.com or call (800) 964-7444 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 a non-preferred 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 a non-preferred provider for some services (such as lab work). 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	40% 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.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---------- None ----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	20% coinsurance	Not covered	Limited to: 30 day supply retail prescription 90 day supply mail order prescription
	Preferred brand drugs	20% coinsurance	Not covered	
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	20% coinsurance	Not Covered	Limited to: 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---------- None ----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.
If you need immediate medical attention	Emergency room care	20% coinsurance		Includes all related expenses.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% coinsurance	Includes all related expenses.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	See the Plan's Schedule of Benefits for PPO Special Notes.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---------- None ----------
	Inpatient services	20% coinsurance	40% coinsurance	Penalties for failure to obtain pre-authorization for services. Refer to page 2.1 of the Plan Document.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Charges for Office visits are considered under the global delivery fee. Cost sharing does not apply for preventive services. 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. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Occupational, Physical, Pulmonary and Speech-limited to 20 visits per calendar year. Cardiac Rehab-limited to 36 visits per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	Limitations may apply based on the type of service rendered. Refer to your plan document.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---------- None ----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Hospice services	20% coinsurance	40% coinsurance	---------- None ----------
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	---------- None ----------
	Children's glasses	Not Covered	Not Covered	---------- None ----------
	Children's dental check-up	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)
- Experimental/ Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Routine Eye care (Adult)
- Routine Foot Care
- Sex Transformation or sexual dysfunctions

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

- Chiropractic Care-limited to 12 visits per calendar year
- Private Duty Nursing-limited to 82 per calendar year and-limited to 164 visits per lifetime.
- Weight Loss Programs-individual's weight must be in excess of 170% of standard weight tables

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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to http://www.in.gov/idoi/2547.htm#2.

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 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.

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	$3000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *Pharmacy coinsurance*	20%

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	$3000
Copayments	$0
Coinsurance	$1900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,900**

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

The plan's overall deductible	$3000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *Pharmacy coinsurance*	20%

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	$3000
Copayments	$0
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,030**

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

The plan's overall deductible	$3000
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *Pharmacy coinsurance*	20%

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	$2,400
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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