



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 1-888-292-0272. 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: |
|--|---|---|
| <p>What is the overall deductible?</p> | <p>For participating providers \$1,000 individual/\$2,000 family; For non-participating providers \$2,000 individual/\$4,000 family.</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Preventive care and primary care services are covered before you meet your deductible.</p> | <p>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/</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>For participating providers \$6,600 individual/ \$13,200 family; for non-participating providers \$19,800 individual / \$39,600 family.</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billing charges, penalty for not obtaining Preauthorization and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a participating provider?</p> | <p>Yes. See www.aetna.com/asa for a list of participating providers.</p> | <p>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-participating 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 participating provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see the specialist you choose without a referral.</p> |



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 |
|--|--|---|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating 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, then covered at 100% | 50% coinsurance | Copayment is not subject to any Deductible . Copay applies to exam charge only. Does not include office surgery. |
| | Specialist visit | \$50 copay /visit, then covered at 100% | 50% coinsurance | 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. | 50% coinsurance | 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) | 20% coinsurance | 50% coinsurance | Inpatient services are subject to deductible and coinsurance . Deductible and coinsurance are waived for covered charges for outpatient services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | 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 |
|--|--|--|--|--|
| | | Participating Provider (You will pay the least) | Non Participating 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.myCigna.com | Generic drugs (Tier 1) | \$20 copay retail/\$60 copay mail order | Not covered | 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) | \$50 copay retail/\$150 copay mail order | Not covered | 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) | \$75 copay retail/\$225 copay mail order | Not covered | 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) | 20% coinsurance | Not covered | To receive the network provider benefit, you must obtain specialty drugs from a specialty pharmacy provider as designated by us. Call 1-800-MyCigna for further information. Specialty drugs obtained from a non-designated specialty pharmacy provider will not be covered. Authorization is required. Benefits will not be paid for any specialty drugs that are not authorized by the Medical Review Manager. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Preauthorization is required. If not received, a penalty will be applied. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|--|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | Non-emergency use will result in a reduction of charges up to the preauthorization penalty amount. The penalty is not covered. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | To the nearest Acute Medical Facility that can treat the sickness or injury. |
| | Urgent care | \$75 copay /visit, then covered at 100% | 50% coinsurance | Copayment is not subject to any Deductible . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Preauthorization is required. If not received, a penalty will be applied. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | Preauthorization is required. If not received, a penalty will be applied. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 copay /visit, then covered at 100%. 50% coinsurance for other services. | 70% coinsurance | Limited to 40 visits per year. Copayments apply to the office visit charge only. Any other services covered under your plan are subject to deductible and coinsurance . |
| | Inpatient services | 50% coinsurance | 70% coinsurance | Preauthorization 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 |
|---|---|---|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you are pregnant | Office visits | \$50 copay /visit, then covered at 100% | 50% coinsurance | Copayment is not subject to any Deductible . Copay applies to exam charge only. See Plan Document for other services. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | Preauthorization is required. If not received, a penalty will be applied. Limited to 60 visits per year. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | 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 |
|---|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Habilitation services | 20% coinsurance | 50% coinsurance | 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 | 20% coinsurance | 50% coinsurance | Preauthorization is required. If not received, a penalty will be applied. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Preauthorization is required for amounts greater than \$1,500. If not received, a penalty will be applied. |
| | Hospice services | 20% 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 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 1-888-292-0272 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 1-888-292-0272.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-292-0272.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-292-0272.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-292-0272.

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)

Managing Joe's type 2 Diabetes

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

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [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*)

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*)

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 | \$12,700 |
|---------------------------|-----------------|

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

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

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$1,500 |
| Coinsurance | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,560 |

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$1,300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,120 |

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$300 |
| Coinsurance | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,600 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.