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 1-800-435-5694 or visit us at www.pbaclaims.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 www.healthcare.gov/sbc-glossary/ or call 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: **$1,800** Individual / **$3,600** Family Non-PPO: **$2,000** Individual / **$6,000** Family Copayments don't apply to the deductible.	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. PPO preventive care, services subject to copays (unless otherwise stated), and prescription drugs 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?	PPO: **$2,600** Individual / **$5,200** Family Non-PPO: **$4,200** Individual / **$8,600** Family Under your HRA, the plan will reimburse medical expenses up to $1,000 for Single Coverage or $1,750 for Family Coverage.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	The out-of-pocket limit does not include any drug manufacturer funded copay assistance under the CAAP Rx program, non-compliance penalties, premiums, balance-billing charges, 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 network providers visit www.myCigna.com or call (800) 435-5694	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
		PPO Provider (You will pay the least)	Non-PPO 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	PCP office visit copay: $25 You pay only the office visit copay for your first 4 office visits during a calendar year (PCP and Specialist visits combined). After that, you pay your deductible, office visit copay and 10% coinsurance for the remainder of the calendar year.	30% coinsurance	The deductible and coinsurance apply to all services performed during an office visit. A Primary Care Physician is a Physician who has a majority of their practice in general medicine, internal medicine, family practice, obstetrics/gynecology, general pediatrics, or professionals treating mental health or substance abuse.
	Specialist visit	Specialist office visit copay: $35 You pay only the office visit copay for your first 4 office visits during a calendar year (PCP and Specialist visits combined). After that, you pay your deductible, office visit copay and 10% coinsurance for the remainder of the calendar year.	30% coinsurance	The deductible and coinsurance apply to all services performed during an office visit. A Specialist includes but is not limited to a pulmonologist (asthma), endocrinologist, cardiologist, orthopedic specialist, etc.
	Office services	10% coinsurance	30% coinsurance	————none————
	Chiropractic services	10% coinsurance	30% coinsurance	40 visits per 6-month period limit
	Chiropractic maintenance	50% coinsurance	50% coinsurance	$30 visit limit and 1 visit per month limit (includes Naprapath and massage treatment)
	Preventive care/ screening/immunization	No charge (no deductible)	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (800) 759-3203 serve-you-rx.com	Generic drugs	$5 copay/preferred generic drugs (retail) $10 copay/prescription (retail) $15 copay/prescription (mail order)		Deductible does not apply. Cost sharing does not apply to certain preventive services. Limits: 34-day supply (retail); 102-day supply (mail order) Specialty drug limit: 30-day supply; however, split fill program may limit first month's supply (1st fill limited to 15-day supply with subsequent 15-day supply refill; 30-day supply max. thereafter).
	Formulary brand drugs	$30 copay/prescription (retail) $35 copay/prescription (mail order)		
	Non-Formulary brand drugs	$50 copay/prescription (retail) $55 copay/prescription (mail order)		
	Specialty drugs	$75 copay/prescription *Your copay may be less under the CAAP Rx program by using drug manufacturer copay assistance when available.*		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	————none————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	————none————
If you need immediate medical attention	Emergency room care	$200 copay, deductible, and 10% coinsurance ER physician: $25 copay	Same as PPO	Emergency room care when due to an accident: the copay is waived.
	Emergency medical transportation	10% coinsurance	Same as PPO	————none————
	Urgent care	Physician: $25/visit (no deductible) Facility: 10% coinsurance	30% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. The non-compliance penalty is $500.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office visits	The same as a primary care office visit (see page 2)	30%coinsurance	————none————
	Outpatient services	10% coinsurance	30% coinsurance	————none————
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required. The non-compliance penalty is $500.
If you are pregnant	Office visits	The same as a primary care office visit (see page 2)	30% coinsurance	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	————none————
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Preauthorization may be required. The non-compliance penalty is $500.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	————none————
	Rehabilitation services	10% coinsurance	30% coinsurance	————none————
	Habilitation services	10% coinsurance	30% coinsurance	————none————
	Skilled nursing care	10% coinsurance	30% coinsurance	Facility: 120 days per calendar year. Preauthorization is required; non-compliance penalty is $500.
	Durable medical equipment	10% coinsurance	30% coinsurance	————none————
	Hospice services	10% coinsurance	30% coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	$300 max/year for exam, lenses, contacts, and frames.
	Children's glasses	No Charge	No Charge	
	Children's dental checkup	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care	• Non-emergency care when traveling outside of the U.S.
• Cosmetic surgery	• Long-term care	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment: 25% coinsurance applies both in and out-of-network (limited to 4 completed oocyte retrievals while covered by the Plan)	• Routine eye care ($300 combined max for exam, lenses and frames)
• Chiropractic care	• Private duty nursing	• Weight loss programs ($300 max while covered under the Plan. See your plan document for details.)
• Hearing aids		

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 or the Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694.

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 **1-800-435-5694.**

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	**$1,800**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,800
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$2,615**

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

The plan's overall deductible	**$1,800**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$360
Copayments	$1,505
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,865**

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

The plan's overall deductible	**$1,800**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,230
Copayments	$340
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

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