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 www.acsbenefitservices.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 1-855-249-9574 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers $2,500 individual / $5,000 family; Non-network providers $5,000 individual / $10,000 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. Network: Preventive care/screening/immunization.	This plan covers some items and services even if you haven't 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?	Network providers $2,500 individual / $5,000 family; Non-network providers $5,000 individual / $10,000 family. Includes deductibles, coinsurance, and copayments.	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?	Premiums; balance billing charges; health care this plan doesn't cover; penalties; reductions; and expenses exceeding plan limits.	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 PPO preferred network providers visit CIGNA at www.myCigna.com or call 1-855-249-9574.	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-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 a non-network provider for some services (such as lab work). Check with your provider before you get services.

* For more information about limitations and exceptions, see the plan or policy document or call 1-855-249-9574.

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	No charge after deductible	30% coinsurance	None
	Specialist visit	No charge after deductible	30% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	Screenings: 30% coinsurance; All other services: 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)	No charge after deductible	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance	Services may be denied if not preauthorized.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sonapharmacybenefits.com.	Generic drugs	Retail: $10 copayment; Mail Order: $30 copayment.		Deductible does not apply. Copayments are per prescription or refill and per 30-day supply. Certain preventive drugs are covered with $0 copayment, including prescribed generic contraceptives and tobacco cessation medications. Retail is up to a 30-day supply and Mail Order is up to a 90-day supply.
	Preferred brand drugs	Retail: $35 copayment; Mail Order: $105 copayment.		
	Non-preferred brand drugs	Retail: $50 copayment; Mail Order: $150 copayment.		
	Specialty drugs	25% coinsurance with minimum $50 coinsurance, but no more than $100 maximum per prescription or refill		Deductible does not apply. Covers up to a 30-day supply through the specialty pharmacy.

* For more information about limitations and exceptions, see the plan or policy document or call 1-855-249-9574.

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)	No charge after deductible	30% coinsurance	Services may be denied if not preauthorized.
	Physician/surgeon fees	No charge after deductible	30% coinsurance	None
If you need immediate medical attention	Emergency room care	No charge after deductible		None
	Emergency medical transportation	No charge after deductible		None
	Urgent care	No charge after deductible	No charge after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance	Services may be denied if inpatient hospitalization is not preauthorized.
	Physician/surgeon fees	No charge after deductible	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	30% coinsurance	None
	Inpatient services	No charge after deductible	30% coinsurance	Services may be denied if inpatient hospitalization is not preauthorized.
If you are pregnant	Office visits	No charge after deductible	30% coinsurance	Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Coverage is provided for covered employee and spouse only.
	Childbirth/delivery professional services	No charge after deductible	30% coinsurance	
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% coinsurance	30 visits for occupational, physical and speech therapy combined with Rehabilitation services.
	Rehabilitation services	No charge after deductible	30% coinsurance	Visit limits for rehabilitation services are per person per plan year (visit limits are a combination of network providers and non-network providers). 30 visit limit combined for chiropractic, occupational and physical therapy. 30 visit limit for speech therapy.

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)	
				Services may be denied if inpatient rehabilitation is not preauthorized. Separate limit from Habilitation services.
	Habilitation services	No charge after deductible	30% coinsurance	Visit limits for habilitation services are per person per plan year (visit limits are a combination of network providers and non-network providers). 30 visit limit combined for occupational and physical therapy. 30 visit limit for speech therapy. Limits do not apply when related to autism. Separate limit from Rehabilitation services.
	Skilled nursing care	No charge after deductible	30% coinsurance	60 days limit for inpatient skilled nursing facility care per person per plan year (visit limits are a combination of network providers and non-network providers). Services may be denied if an inpatient skilled nursing facility stay is not preauthorized.
	Durable medical equipment	No charge after deductible	30% coinsurance	Charges for rental of durable medical equipment that exceed the allowed charge for such equipment are not covered.
	Hospice services	No charge after deductible	30% coinsurance	Services may be denied if inpatient hospice is not preauthorized.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Limited to one exam per plan year.
	Children's glasses	Not covered		No coverage provided.
	Children's dental check-up	No charge, deductible does not apply	Not covered	Limited to oral health risk assessment only.

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (30 visit limit combined with occupational and physical therapy)
- Hearing aids (limitations apply, see plan)
- Infertility treatment (limitations apply, see plan)
- Private-duty nursing
- Routine eye care (Adult) (1 exam per plan year)

Your Rights to Continue Coverage: For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 ACA Benefit Services at 1-866-257-3259.

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 1-866-257-3259.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-257-3259.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-257-3259

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-257-3259.

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 or call 1-855-249-9574.

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	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,560

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,520

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,510

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

* For more information about limitations and exceptions, see the plan or policy document or call 1-855-249-9574.