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 1-866-257-3259 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $2,500 individual / $5,000 family; for 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network: Preventive care/screening/immunization including pre-natal maternity.	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?	For network providers $5,000 individual / $5,000 family; for non-network providers $10,000 individual / $10,000 family. Includes deductibles and coinsurance.	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, the overall family out-of-pocket limit must be 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.	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.
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	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	30% coinsurance	Includes all services performed during annual physical exams including tests/screenings with the exception of CT Scans and MRIs. 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	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.southernscripts.net.	Generic drugs	**Non-First Choice Retail up to a 30-day supply**: 30% coinsurance **First Choice Retail & Mail Order up to a 90-day supply**: 30% coinsurance		Deductible does apply. Certain preventive drugs are covered with $0 coinsurance, including prescribed generic contraceptives and tobacco cessation medications. If you are eligible to receive a subsidy through a manufacturer copay program, your copay under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. A detailed schedule of subsidies available through manufacturer copay programs under the Variable Copay™ Program is available at www.crxspecialty.com. If you are receiving a prescription drug through a manufacturer free drug program and you enroll in the manufacturer Free Drug Initiative, that drug will not be covered under the plan.
	Preferred brand drugs	**Non-First Choice Retail up to a 30-day supply**: 30% coinsurance **First Choice Retail & Mail Order up to a 90-day supply**: 30% coinsurance		
	Non-preferred brand drugs	**Non-First Choice Retail up to a 30-day supply**: 50% coinsurance **First Choice Retail & Mail Order up to a 90-day supply**: 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)	
	Specialty drugs	Follows coinsurance based on generic, preferred brand and non-preferred brand listed above.		Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	**Women's Preventive care/screening**: No charge, deductible does not apply. **All other services**: 20% coinsurance	**Women's Preventive care/screening**: 15% coinsurance **All other services**: 50% 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, spouse, and dependent daughter.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visit limit for home health care per person per calendar year (visit limits are a combination of network providers and non-network providers).

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)	
	Rehabilitation services	20% coinsurance	50% coinsurance	Visit limits for rehabilitation services are per person per calendar year (visit limits are a combination of network providers and non-network providers). 60 visit limit combined for occupational, physical and speech therapy. Limits do not apply when related to autism. Preauthorization is required for inpatient rehabilitation. Separate limit from Habilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	Visit limits for habilitation services are per person per calendar year (visit limits are a combination of network providers and non-network providers). 60 visit limit combined for occupational, physical and speech therapy. Limits do not apply when related to autism. Separate limit from Rehabilitation services.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days limit for inpatient skilled nursing facility care per person per calendar year (visit limits are a combination of network providers and non-network providers). Preauthorization is required for an inpatient skilled nursing facility.
	Durable medical equipment	20% coinsurance	50% coinsurance	Charges for rental of durable medical equipment that exceed the allowed charge for such equipment are not covered.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required for inpatient hospice.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply		Limited to one exam in a 24-month period.
	Children's glasses	Not covered		No coverage provided.
	Children's dental check-up	No charge, deductible does not apply	30% coinsurance	Limited to oral health risk assessment only.

* For more information about limitations and exceptions, see the plan or policy document or call 1-866-257-3259.

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)	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • 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.)		
• Chiropractic care (20 visit limit per calendar year)	• Hearing aids (limited to 1 hearing aid per ear to a maximum of $2,500 every 36 months for member to age 22)	• Routine eye care (Adult)

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 Benefit 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 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 1-866-257-3259; or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272); 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 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.

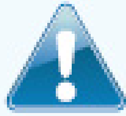
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-257-3259

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 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	$2,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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 [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 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	$2,500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

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

- The plan's overall deductible $2,500
- Specialist [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 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	$2,500
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,560**

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