

 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, go to <https://www.acuity-grp.com/> or call 1-866-872-6356. 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.dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For <u>Network providers</u> \$5,000/individual or \$10,000/family; for <u>Non-network providers</u> \$10,000/individual or \$20,000/family	Generally, you must pay all the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see chart starting on page 2 for other costs for services this plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>Network providers</u> \$6,550/individual or \$13,100/family; for <u>Non-network providers</u> \$13,100/individual or \$26,200/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balanced-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://hcpdirectory.cigna.com for a list of participating providers	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Specialist visit	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Preventive care/screening/immunization	0% coinsurance	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Chiropractic Care	Professional Fees: 20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	20 visit limitations on Chiropractic Care
If you have a test	Diagnostic test (blood work)	Facility: 20% coinsurance, after deductible Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Imaging (X-Ray, CT/PET scans, MRIs)	Facility: 20% coinsurance, after deductible Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.truescripts.com	Generic drugs	1-30 day supply \$15 <u>copayment/prescription</u> after deductible 31-90 day supply \$30 <u>copayment/prescription</u> after deductible	Not covered	Copayments apply to Retail and/or Mail Order.
	Preferred brand drugs	1-30 day supply \$65 <u>copayment/prescription</u> after deductible 31-90 day supply \$130 <u>copayment/prescription</u> after deductible	Not covered	
	Non-preferred brand drugs	1-30 day supply \$100 <u>copayment/prescription</u> after	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible 31-90 day supply \$200 <u>copayment</u> /prescription after deductible		
	Specialty drugs	50% coinsurance after deductible	Not covered	Prior authorization is required for all Specialty drugs. Contact TrueScripts at 844-257-1955. <u>Copayments</u> listed are for 1-30 day supply/prescription. 31-90 day supply/prescription Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility: 20% coinsurance, after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	Physician/surgeon fees	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
If you need immediate medical attention	Emergency room care	Facility: 20% coinsurance, after deductible Professional Fees: 20% after deductible	Facility: 20% coinsurance, after deductible Professional Fees: 20% after deductible	Out of network is subject to plan allowable fee.
	Emergency medical transportation	20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Urgent care	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Facility: 20% coinsurance, after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health and substance abuse services	Physician/surgeon fees	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Outpatient services	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Inpatient services	Facility: 20% coinsurance, after deductible Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
If you are pregnant	Office visits	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Childbirth/delivery professional services	Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
	Childbirth/delivery facility services	Facility: 20% coinsurance, after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% after deductible,	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	<u>Rehabilitation services</u>	20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Limited to 20 visits per Calendar Year for physical, and occupational therapies combined, 20 visits for Speech, 15 visits for Chiropractic. Subject to plan allowable
	<u>Habilitation services</u>	20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Limited to 20 visits per Calendar Year, combined with the above therapies.
	<u>Skilled nursing care</u>	Facility: 20% of plan allowable, after deductible Professional Fees: 20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	<u>Durable medical equipment</u>	20% after deductible	Deductible, 40% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care				(\$2,500 maximum). Subject to plan allowable.
				(Limited to 12 month rental or purchase price, whichever is less)
	Hospice services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	Children's eye exam	No charge	Not covered	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) - Hearing Aids (Adult)	- 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	- Durable medical equipment - Hearing Aids (under age 18) - 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: 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](http://www.HealthCare.gov), 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: Acuity at 1-866-872-6356 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

[* For more information about limitations and exceptions, see the plan or policy document at <https://www.acuity-grp.com>]

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](#).

[Language Access Services](#):

[Spanish (Español): Para obtener asistencia en Español, llame al 1-866-872-6356]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-872-6356]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-872-6356]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-872-6356]

— *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](#) \$5,000
- [Specialist](#) [*cost sharing*] 80%
- Hospital (facility) [*cost sharing*] 80%
- Other [*cost sharing*] 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$10
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,570

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [*cost sharing*] 80%
- Hospital (facility) [*cost sharing*] 80%
- Other [*cost sharing*] 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,920

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [*cost sharing*] 80%
- Hospital (facility) [*cost sharing*] 80%
- Other [*cost sharing*] 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,810

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