**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 1-800-846-0611. 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 call 1-800-846-0611 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network providers: **$250**/individual or **$750**/family per calendar year.<br>Out-of-network providers: **$1,000**/individual or **$3,000**/family per calendar year. | 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. Prescription drugs and these in-network services are covered before you meet your deductible: Preventive Care, Physician visits for Outpatient Mental Health/Chemical Dependency, Physician Visits, certain lab tests, and Office Surgeries. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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?** | In-network providers: **$2,000**/person or **$6,000**/family per calendar year.<br>Out-of-network providers: **$5,000**/person or **$15,000**/family per calendar year. | 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. |
| **What is not included in the out-of-pocket limit?** | Copayments, premiums, balance billing charges, deductibles, penalties for failure to obtain | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| | | |
|---|---|---|
| | preauthorization for services, and health care this plan does not cover. | |
| **Will you pay less if you use a network provider?** | Yes. See www.cignasharedadministration.com or call CIGNA at 1-800-768-4695 or the Trust Office at 1-800-846-0611 for a list of network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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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) | 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 | $25 copayment/visit; deductible does not apply. | 50% coinsurance | -- None -- |
| | Specialist visit | $25 copayment/visit; deductible does not apply. | 50% coinsurance | -- None -- |
| | Preventive care/screening/ immunization | $25 copayment/exam; deductible does not apply. | 50% coinsurance | Refer to the SPD for benefit limitations. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | Not subject to deductible if performed at independent laboratory or in office for both in-network and out-of-network. |
| | 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.cigna.com or by calling CIGNA Pharmacy at 1-800-244-6224. | Generic drugs (Tier 1) | $10 copayment/ prescription - Retail $20 copayment/ prescription - Mail Order; deductible does not apply. | Not covered | If brand is chosen when generic is available, you must pay generic copayment plus difference in cost between generic and brand.<br><br>30-day supply for Retail. 90-day supply for Mail Order. |
| | Preferred brand drugs (Tier 2) | $20 copayment/ prescription (Tier 2 Brand) - Retail $40 copayment/ prescription (Tier 2 Brand) - Mail Order; deductible does not apply. | | |

| 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 drugs to treat your illness or condition –** *Con't* | Non-preferred brand drugs (Tier 3) | $40 copayment/ prescription (Tier 3 Brand) - Retail $80 copayment/ prescription (Tier 3 Brand) - Mail Order; deductible does not apply. | Not covered | If brand is chosen when generic is available, you must pay generic copayment plus difference in cost between generic and brand.<br><br>30-day supply for Retail. 90-day supply for Mail Order. |
| | Specialty drugs (Tier 4) | $40 copayment/ prescription - Retail $80 copayment/ prescription - Mail Order; deductible does not apply. | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 copayment/ confinement & 20% coinsurance deductible does not apply. | $100 copayment/ confinement & 20% coinsurance deductible does not apply. | -- None -- |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | -- None -- |
| **If you need immediate medical attention** | Emergency room care | $100 copayment/visit | $100 copayment/visit | Subject to copay and UCR charges, regardless of network status and deductible. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Plan pays 80% after CIGNA in-network deductible using UCR charges, regardless of network status. |
| | Urgent care | $25 copayment/visit | 50% coinsurance | -- None -- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 copayment/per confinement & 20% coinsurance | Not covered | Requires preauthorization or the plan will only pay 50% of the amount it otherwise would have paid. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | -- None -- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copayment/ office visit & 20% coinsurance other outpatient services | 50% coinsurance | -- None -- |

| 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) | |
| | Inpatient services | $100 copayment/ confinement & 20% coinsurance | Not covered | Requires preauthorization or the plan will only pay 50% of the amount it otherwise would have paid. |
| **If you are pregnant** | Office visits | $25 copayment/visit; deductible does not apply. | 50% coinsurance | Dependent children are not eligible for this benefit. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | $100 copayment/ confinement & 20% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Limit one visit per day, 100 visits per calendar year. Requires preauthorization or the plan will only pay 50% of amount it would have paid. Outpatient Physical Therapy limited to 25 visits/calendar year. |
| | Rehabilitation services | 20% coinsurance | Inpatient, Not Covered Outpatient, 50% coinsurance | Requires preauthorization or the plan will only pay 50% of amount it would have paid. Outpatient Physical Therapy limited to 25 visits/calendar year. Speech, Hearing, and Occupational Therapy limited to 25 visits/calendar year. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | -- None -- |
| | Skilled nursing care | $100 copayment/ confinement & 20% coinsurance | Not covered | 100-day calendar year max. Must follow inpatient hospital stay. Requires preauthorization or the plan will only pay 50% of amount it would have paid. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Requires preauthorization for any cost over $500 or plan will only pay 50% of amount it would have paid. |
| | Hospice services | $100 copayment + 20% coinsurance | 20% coinsurance for outpatient services. Inpatient services are not | Life expectancy must be six months or less. Requires preauthorization or the plan will only pay 50% of amount it otherwise would have |

| 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) | |
| | | | covered. | paid. |
| **If your child needs dental or eye care** | Children's eye exam | $10 copayment/exam | $10 copayment/exam & all charges over $30 | Limited to one exam once every year. |
| | Children's glasses | $25 copayment/frame | $25 copayment/frame & all charges over | See the SPD for applicable allowable allowances and other details. |
| | Children's dental check-up | 20% coinsurance | Not covered | Routine oral examinations limited to 2 visits per covered person/year (once every 6 months). $500 shared calendar year max benefit for covered dependents, except dependents under 19 years of age. |

## 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
- Dependent child's pregnancy or complications related thereto
- Hearing aids
- Infertility treatment
- Long-term care (except for specific items covered under the plan (i.e. skilled nursing care))
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for specific items covered under the plan (i.e. medically necessary home health care, hospice services, etc.))
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Chiropractic care (up to 5 visits per calendar year)
- Dental care (Adult) (maximum of $750 per calendar year)
- 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 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, 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 1-800-846-0611. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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 1-800-846-0611.

*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** $250
- **Specialist copayment** $25
- **Hospital (facility) coinsurance & copay** 20%, $100 copayment
- **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)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $330 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$2,680** |

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

- **The plan's overall deductible** $250
- **Specialist copayment** $25
- **Hospital (facility) coinsurance & copay** 20%, 100 copayment
- **Other coinsurance** 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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $810 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $220 |
| **The total Joe would pay is** | **$1,580** |

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

- **The plan's overall deductible** $250
- **Specialist copayment** $25
- **Hospital (facility) coinsurance & copay** 20%, $100 copayment
- **Other coinsurance** 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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $200 |
| Coinsurance | $120 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$570** |

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