




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.theamericanworker.com](http://www.theamericanworker.com) or call 1-855-495-1192. 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 1-855-495-1192 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$6,000</b> per person / <b>\$12,000</b> per family for Network Providers; <b>\$10,000</b> per person / <b>\$20,000</b> per family for Out-of-Network Providers.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$6,000</b> per person / <b>\$12,000</b> per family for Network Providers; <b>\$11,000</b> per person / <b>\$22,000</b> per family for Out-of-Network Providers.	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family out-of-pocket limit has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, amounts over <a href="#">UCR</a> , cost containment penalties and <a href="#">excluded services</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	<b>Yes.</b> See <a href="http://www.mycigna.com">www.mycigna.com</a> or call 1-855-495-1192 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your provider before you get services.
Do you need a <a href="#">referral</a> to	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</a> ?		

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	<a href="#">Specialist</a> visit	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	<a href="#">Preventive care/screening/immunization</a>	No Charge	10% coinsurance after deductible is met	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Certain age restrictions may apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible is met	10% coinsurance after deductible is met	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available by calling CerpasRx at 844-636-7506 or visiting <a href="#">www.CerpasRx.com</a>	Generic drugs	No Charge after deductible is met	Not Covered	Retail: up to a 31-day supply; Mail Order: up to a 90-day supply.
	Preferred brand drugs	No Charge after deductible is met	Not Covered	You may need to obtain certain specialty drugs through a pharmacy designated by CerpasRx.
	Non-preferred brand drugs	No Charge after deductible is met	Not Covered	
	<a href="#">Specialty drugs</a>	No Charge after deductible is met	Not Covered	Certain drugs may have a <a href="#">pre-authorization</a> requirement.  Generic contraceptives are covered at No Charge.  Not all drugs are covered.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.theamericanworker.com](#).

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible is met	10% coinsurance after deductible is met	<u>Preauthorization</u> is required for procedures that have the potential to be cosmetic in order to avoid a 25% benefit reduction.
	Physician/surgeon fees	No Charge after deductible is met	10% coinsurance after deductible is met	<u>Preauthorization</u> is required for procedures that have the potential to be cosmetic in order to avoid a 25% benefit reduction.
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge after deductible is met	No Charge after in-network deductible is met	---None---
	<a href="#">Emergency medical transportation</a>	No Charge after deductible is met	No Charge after in-network deductible is met	---None---
	<a href="#">Urgent care</a>	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible is met	10% coinsurance after deductible is met	<u>Preauthorization</u> is required in order to avoid a 25% benefit reduction.
	Physician/surgeon fees	No Charge after deductible is met	10% coinsurance after deductible is met	<u>Preauthorization</u> is required in order to avoid a 25% benefit reduction.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Inpatient services	No Charge after deductible is met	10% coinsurance after deductible is met	<u>Preauthorization</u> is required in order to avoid a 25% benefit reduction.
If you are pregnant	Office visits	No Charge after deductible is met	10% coinsurance after deductible is met	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge after deductible is met	10% coinsurance after deductible is met	Inpatient services must be <u>preauthorized</u> for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay in order to avoid a 25% benefit reduction.
	Childbirth/delivery facility services	No Charge after deductible is met	10% coinsurance after deductible is met	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge after deductible is met	10% coinsurance after deductible is met	Limited to 90 visits per calendar year. Services must be <u>preauthorized</u> in order to avoid a 25% benefit reduction.
	<a href="#">Rehabilitation services</a>	No Charge after deductible is met	10% coinsurance after deductible is met	Limited to 20 visits per calendar year for Physical, Speech, Occupational, Pulmonary

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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)	
				and Cognitive therapy. Limited to 36 visits per calendar year for Cardiac therapy.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	Excluded Service
	<a href="#">Skilled nursing care</a>	No Charge after deductible is met	10% coinsurance after deductible is met	Services must be <u>preauthorized</u> in order to avoid a 25% benefit reduction. Limited to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	<a href="#">Hospice services</a>	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (Adult)</li> <li>• Habilitation services</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Child)</li> <li>• Hearing aids</li> <li>• Non-emergency care when traveling outside the U.S</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Eye care (Child)</li> <li>• Infertility treatment</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>• Chiropractic (limited to 20 visits per CYM)</li> <li>•</li> <li>•</li> </ul>

**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](http://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](http://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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.theamericanworker.com](http://www.theamericanworker.com).

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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? No**

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 855-495-1192.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,060</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,420</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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