



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. 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.healthcare.gov/sbc-glossary/ or call 1-844-334-9599 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$250 Individual / \$500 Family for In-Network \$500 Individual / \$1,000 Family for Out-of-Network Deductible is embedded.	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. In-Network preventive care and services covered at "No charge".	This plan covers some items and services even if you haven't yet 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 ?	\$1,250 Individual / \$2,500 Family for In-Network \$3,750 Individual / \$7,500 Family for Out-of-Network Out-Of-Pocket Limit is embedded.	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 ?	Premiums , balance-billing charges, Pre-Certification penalties, and health care this plan doesn't cover.	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. See www.cigna.com 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 .

 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 copay , deductible does not apply	50% coinsurance after deductible	None
	Specialist visit	\$45 copay , deductible does not apply	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	Labs performed during network office visit are included in office visit copay.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on imaging. \$500 penalty applies if not obtained.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://gomarpai.com	Generic drugs	Retail/Mail Order: \$0 copay / prescription, deductible does not apply.	Not covered	Prior authorization may be required on certain prescription drugs . Benefits may vary if more than a 30-day supply is needed.
	Preferred brand drugs	Retail: \$35 copay / prescription, deductible does not apply. Mail Order: \$105 copay / prescription, deductible does not apply.	Not covered	
	Non-preferred brand drugs	Retail: \$75 copay / prescription, deductible does not apply. Mail Order: \$225 copay / prescription, deductible does not apply.	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)	
	Specialty drugs	\$200 copay /prescription, deductible does not apply	Not covered	Specialty drugs with a gross cost of \$2,500 per month are covered by when coordinated with the PBM's Patient Advocacy Program. The Plan may permit for at least one (1) 30-day fill for each of these drugs during the Benefit Year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required on surgical procedures. \$500 penalty applies if not obtained.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	Same as In-Network	None
	Emergency medical transportation	20% coinsurance after deductible	Same as In-Network	None
	Urgent care	\$45 copay , deductible does not apply	Same as In Network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. \$500 penalty applies if not obtained.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$25 copay , deductible does not apply Outpatient: 20% coinsurance after deductible	50% coinsurance after deductible	None.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on inpatient services. \$500 penalty applies if not obtained.
If you are pregnant	Office visits	No Charge	No Charge	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)	
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	None
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. \$500 penalty applies if not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. \$500 penalty applies if not obtained. 60 visits/Calendar Year.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Physical, speech, occupational cardiac rehabilitation limited to 35 visits per Calendar Year, combined.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. \$500 penalty applies if not obtained. 25 days/ Calendar Year.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification applies to DME, Orthotics, and Prosthetics. \$500 penalty applies if not obtained.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required for inpatient. \$500 penalty applies if not obtained. 15 visits/days per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam per Calendar Year
	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 | • Hearing aids | • Private duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| • Cosmetic Alteration Drugs | • Medical Devices excluding certain diabetic supplies | |
| • Blood Components | | |
| • Over The Counter (OTC) Medications | | |

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

- Chiropractic care (25 visits per Plan Year)

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 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: **Marpai at Attn: Appeal's Coordinator, PO Box 211291 Eagan, MN 55121 or 1-844-334-9599 .**

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 1-844-334-9599 .

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-334-9599 .

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-334-9599 .

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-334-9599 .

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	\$250
■ Specialist copayments	\$45
■ Hospital (facility) coinsurance	20%
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$45
Coinsurance	\$2,481
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,836

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 copayments	\$45
■ Hospital (facility) coinsurance	20%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$25
Coinsurance	\$1,065
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,360

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist copayments	\$45
■ Hospital (facility) coinsurance	20%
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$510
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$760

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