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, contact Insurance Management Services. 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.imstpa.com or call 1-800-687-5944 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Individual $6,900; Family $13,800/ Non-Network not covered. Deductible applies to all benefits except Preventive Care	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.	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?	There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. **Services for Inpatient Admissions, Outpatient Surgery, MRI's, PET/CT Scans, Transplants, Chemotherapy, and Dialysis must be Pre-certified with IMS at 1-800-687-5944.**
What is the out-of-pocket limit for this plan?	In-Network Individual $6,900; Family $13,800; Non-Network not covered	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-billed charges, benefits, paid at 100%, 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. The Network is CIGNA. Visit www.imstpa.com or call 1-800-687-5944 for a list of participating 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 permission from this Plan.

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
		Your Cost If You Use an In-Network Provider	Your Cost if you Use aa Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge, after deductible	Not Covered	None
	Specialist visit	No charge, after deductible	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	Network Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Co-Payment, Co-insurance or deductible) and apply to the following: • Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF. • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease control and Prevention.
If you have a test	Diagnostic test (x-ray, blood work)	No charge, after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No charge, after deductible	Not Covered	CT, PET scans & MRI must be pre-certified with IMS at 1-800-687-5944
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	$20 / prescription (retail) $75 / prescription (90 day retail & mail-order)		Covers up to a 30 day supply (retail); 31 – 90 day supply (P90 and Mail order) Co-pays apply after deductible. Out of Network Pharmacies are not covered.
	Preferred brand drugs	50% up to a maximum of $400 (retail) 50% to $600 maximum for (90 day retail or mail-order)		The In-Network Out-of-Pocket includes the Deductible, Co-insurance and Co-Pays for both the Medical and RX benefits.
	Non-preferred brand drugs			
	Specialty drugs	50% up to a maximum of $600		Must be prior authorized and purchased at CVS Specialty Pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, after Deductible	Not Covered	Outpatient surgery must be Pre-certified with IMS at 1-800-687-5944
	Physician/surgeon fees	No charge, after Deductible	Not Covered	None

If you need immediate medical attention	Emergency room care	No charge, after Deductible	Not Covered	Non Network ER only covered if true emergency and unable to obtain services at In-network ER facility.
	ER transportation	No charge, after Deductible	Not Covered	None
	Urgent care	No charge, after Deductible	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-678-5944
	Physician/surgeon fees	No charge, after Deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, after Deductible	Not Covered	Other Outpatient services other than office visit will be paid at regular benefits
	Inpatient services	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-678-5944
If you are pregnant	Office visits	No charge, after Deductible	Not Covered	Initial visit to determine pregnancy
	Childbirth/delivery professional services	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-687-5944 for vaginal delivers requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
	Childbirth/delivery facility services	No charge, after Deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge, after Deductible	Not Covered	60 visits per calendar year.
	Rehabilitation services	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-678-5944; Limited to 35 visits per calendar year
	Habilitation services	No charge, after Deductible	Not Covered	None
	Skilled nursing care	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-678-5944; Limited to 25 days per calendar year
	Durable medical equipment	No charge, after Deductible	Not Covered	None
	Hospice services	No charge, after Deductible	Not Covered	Inpatient services must be Pre-certified through IMS at 1-800-678-5944
If your child needs dental or eye care	Children's eye exam	No charge, after Deductible	Not Covered	Limited to one exam per year
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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) Covered under dental plan
- Private Duty Nursing
- Infertility Treatments
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Hearing Aids
- Routine Eye care (Adult) Covered under vision plan
- 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
- Diabetic Education

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 al1-800-687-5944
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-687-5944
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-687-5944
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-687-5944

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	$6,900
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)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

The plan's overall deductible	$6,900
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)*

Total Example Cost	**$7,583**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,529
Copayments	$580
Coinsurance	$1,791
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,955**

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

The plan's overall deductible	$6,900
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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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