


# Health Benefit Plan – HSA 4000 PPO Plan


Coverage Period:

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: All levels Plan Type: PPO

 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.groupresources.com](http://www.groupresources.com). 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 1-800-749-9963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-network - <b>\$4,000</b> person <b>\$8,000</b> family Out-of-network - <b>\$6,000</b> person <b>\$12,000</b> family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. The deductible does not apply to preventive services performed in-network.	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="#">co-payment</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 preventive services 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 deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network - <b>\$5,500</b> person <b>\$11,000</b> family Out-of-network - <b>\$8,000</b> person <b>\$16,000</b> family	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 <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed charges</a> , <a href="#">penalties</a> , and health care this <a href="#">plan</a> doesn't cover.	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> ?	Yes. Visit <a href="http://www.mycigna.com">www.mycigna.com</a> to find providers in the Cigna network.	You will pay less if you use a <a href="#">provider</a> in the plan's network. 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</a> charge and what your plan pays ( <a href="#">balance billing</a> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

 All co-payments 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	30% <u>coinsurance</u>	After the <u>deductible</u> , you will pay a \$10 co-payment if you receive telephone consultation services through the telemedicine program.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Preventive care/screening/immunizations</u>	No charge <u>Deductible</u> waived	30% <u>coinsurance</u>	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition For more information about drug coverage, visit <a href="http://www.mycigna.com">www.mycigna.com</a>	Generic drugs	Retail: \$10 <u>co-payment</u> Mail order: \$20 <u>co-payment</u> <u>Deductible</u> applies	Not Covered	Covers up to a 30-day (retail) or 90-day supply (mail order) through Cigna RX
	Preferred brand drugs	Retail: \$35 <u>co-payment</u> Mail order: \$70 <u>co-payment</u> <u>Deductible</u> applies	Not Covered	
	Non-preferred brand drugs	50% <u>co-payment</u> to a maximum of \$100 per prescription retail or \$200 per prescription mail order <u>Deductible</u> applies	Not Covered	
	Specialty drugs	35% <u>co-payment</u> to a maximum of \$300 per prescription <u>Deductible</u> applies	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>co-payment</u> per visit plus 20% <u>coinsurance</u> (In-network <u>deductible</u> and <u>out-of-pocket</u> apply to all providers)		<u>Co-payment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> (In-network <u>deductible</u> and <u>out-of-pocket</u> apply to all providers)		None

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

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<a href="#">Urgent care</a>	\$150 <u>co-payment</u> per visit <u>Deductible</u> applies	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room) <sup>***</sup>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<sup>***</sup> Must be pre-certified or a \$250 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health services and substance use disorder services are covered like any other illness. To determine benefits, please check this grid for the provider or facility that is performing the service		None
	Inpatient services <sup>***</sup>			<sup>***</sup> Must be pre-certified or a \$250 penalty applies.
If you are pregnant	Office visits	Maternity services are covered like any other illness To determine benefits, please check this grid for the provider or facility that is performing the service		None
	Childbirth/delivery professional services			None
	Childbirth/delivery facility services <sup>***</sup>			<sup>***</sup> Pre-certification is not required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage limited to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes physical, speech & occupational therapy
	<a href="#">Habilitation services</a>	Not covered	Not covered	This exclusion will not apply to Autism, ADD, or ADHD
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage limited to 100 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Letter of medical necessity required.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> waived	Not Covered	Limited to one exam per 12-month period
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

## Excluded Services & Other Covered Services:

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check your policy or plan document for other excluded services.)	
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Hearing aids</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
<b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic care (Limited to 26 visits per calendar year)</li><li>• Cosmetic surgery (Limited to treatment of congenital birth defects, and treatment of illness or injury when performed within 24 months of such illness or injury)</li><li>• Dental care (Adult – limited to treatment of accidental injury to sound natural teeth, and setting of a jaw fractured or dislocated in an accident when treatment is received within 12 months after such accident)</li><li>• Infertility treatment (Limited to diagnosis and treatment of underlying medical condition causing infertility - direct attempts to induce pregnancy such as artificial insemination, in vitro fertilization and drug therapy are not covered)</li><li>• Routine eye care (Adult - limited to eye exam only; frames, lenses and contacts are not covered)</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: US Dept of Labor, Employee Benefits Security Administration (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also call Group Resources at (800) 749-9963. 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 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: Group Resources 770-623-8383 or the Department of Labor's Employee Benefit Security Administration (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://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: (202) 727-4559

.....*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](#) \$4,000
- [Specialist](#) 20% coinsurance
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$40
Coinsurance	\$1,720
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,820</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist](#) 20% coinsurance
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$370
Coinsurance	\$240
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,670</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist](#) 20% coinsurance
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>