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. 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 deductible?	In-network - **$500** person **$1,000** family Out-of-network - **$2,500** person **$5,000** family	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. There is no deductible for preventive care or to any office services which have co-payments.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	In-network - **$1,500** person **$3,000** family Out-of-network - **$4,500** person **$9,000** family	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, 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. Visit www.mycigna.com to find providers in the Cigna 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).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

All 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 co-payment per visit.	30% coinsurance	You will pay a $10 co-payment (deductible does not apply) if you receive telephone consultation services through the telemedicine program.
	Specialist visit	$50 co-payment per visit.	30% coinsurance	
	Preventive care/screening/ immunizations	No charge Deductible does not apply	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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mycigna.com	Generic drugs	$10 co-payment retail or $20 co-payment mail order	Not covered	Deductible does not apply Covers up to a 30-day (retail) or 90-day supply (mail order) through Cigna RX
	Preferred brand drugs	$35 co-payment retail or $70 co-payment mail order	Not covered	
	Non-preferred brand drugs	50% co-payment to a maximum of $100 per prescription retail or $200 per prescription mail order	Not covered	
	Specialty drugs	35% co-payment to a maximum of $300 per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery ctr)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care – **Medical emergency**	10% coinsurance (In-network deductible/out-of-pocket maximum apply to all providers)		None
	Emergency room care – **Non-emergency**	10% coinsurance	30% coinsurance	None
	Emergency medical transportation	10% coinsurance (In-network deductible/out-of-pocket maximum apply to all providers)		None

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.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)	
	Urgent care	$150 co-payment per visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)***	10% coinsurance	30% coinsurance	***Must be pre-certified or benefits will be reduced by $250.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health and substance abuse 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***			***Must be pre-certified or benefits will be reduced by $250.
If you are pregnant	Office visits	$25 co-payment per visit	30% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	***Must be pre-certified or benefits will be reduced by $250.
	Childbirth/delivery facility services***	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage limited to 100 days per calendar year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes physical, speech & occupational therapy
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to Autism, ADD, or ADHD
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	Not Covered	Limited to one exam per 12-month period.
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

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.)			
• Bariatric surgery • Habilitation services	• Weight loss programs • Infertility treatment	• Glasses (Adult & Child) • Hearing aids • Long-term care	• Non-emergency care if traveling outside the U.S. • Routine foot care • Dental care (Adult & Child)

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

- Acupuncture
- Chiropractic care
- Cosmetic surgery (Limited to treatment of congenital birth defects, and treatment resulting from an illness or injury if performed within 24 months of the date of such illness or injury)
- Dental care (Adult – limited to treatment of an accidental injury to mouth, teeth, gums and alveolar processes but only if treatment is received within 6 months of such accident - includes the replacement of teeth, and setting of a dislocated or fractured jaw)

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. 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 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.

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.

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

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** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	$500
Copayments	$90
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,850**

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

- **The plan's overall deductible** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	$500
Copayments	$970
Coinsurance	$140
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1670**

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

- **The plan's overall deductible** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	**$1,700**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$660**

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