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, go to https://www.acuity-grp.com/ or call 1-855-357-3368. 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. dol.gov/ebsa/healthreform.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network providers $1,500/individual or $3,000/family; for Non-network providers $3,000/individual or $6,000/family	Generally, you must pay all 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. Preventive care services are covered before you meet your deductible.	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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For Network providers $7,350/individual or $14,700/family; for Non-network providers $14,700/individual or $29,400/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, balanced-billing charges, 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 https://hcpdirectory.cigna.com 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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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	$30 copayment/visit	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Specialist visit	$60 copayment/visit	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Preventive care/screening/ immunization	0% coinsurance	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.
	Chiropractic visit	$20 copayment/visit		Subject to plan allowable
If you have a test	Diagnostic test (blood work)	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Imaging (X-Ray, CT/PET scans, MRIs)	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.truescripts.com	Generic drugs	1-30 day supply $15 copayment/prescription 31-90 day supply $45 copayment/prescription	Not covered	Copayments apply to Retail and/or Mail Order.
	Preferred brand drugs	1-30 day supply $45 copayment/prescription 31-90 day supply $90 copayment/prescription	Not covered	
	Non-preferred brand drugs	1-30 day supply $85 copayment/prescription 31-90 day supply $150 copayment/prescription	Not covered	
	Specialty drugs	Tier 1 - $85 copayment/prescription Tier 2 – 20% copayment/prescription to a $550 maximum Tier 3 – 20% copayment/prescription to a $2,000 maximum	Not covered	Prior authorization is required for all Specialty drugs. Contact TrueScripts at 844-257-1955. Copayments listed are for 1-30 day supply/prescription. 31-90 day supply/prescription Not

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)	
		Tier 4 – 20% copayment/prescription Tier 5 – 50% copayment/prescription		Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Physician/surgeon fees	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need immediate medical attention	Emergency room care	20% after deductible	Facility: 20% after deductible Professional Fees: 20% after deductible	Out of network is subject to plan allowable fee.
	Emergency medical transportation	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Urgent care	$60 copayment/visit	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Physician/surgeon fees	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	$30 copayment/visit	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Inpatient services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If you are pregnant	Office visits	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
	Childbirth/delivery professional services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	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 facility services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	None
If you need help recovering or have other special health needs	Home health care	20% after deductible,	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Rehabilitation services	0% after copayment, per visit	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 20 visits per Calendar Year for physical, and occupational therapies combined, 20 visits for Speech, 15 visits for Chiropractic. Subject to plan allowable.
	Habilitation services	0% after copayment, per visit	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 20 visits per Calendar Year, combined with the above therapies.
	Skilled nursing care	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
	Durable medical equipment	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum). Subject to plan allowable. (Limited to 12 month rental or purchase price, whichever is less)
	Hospice services	20% after deductible	Deductible, 40% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($2,500 maximum).
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	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 https://www.acuity-grp.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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids (Adult)
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Durable medical equipment
- Hearing Aids (under age 18)
- Routine Eye Care (Adult)

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. 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: Acuity at 855-357-3368 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 855-357-3368]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-357-3368]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-357-3368]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-357-3368]

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 https://www.acuity-grp.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	$1,500
Specialist copayment	$60
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$90
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,550**

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

The plan's overall deductible	$1,500
Specialist copayment	$60
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1,500
Specialist copayment	$60
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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