This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.regionalcare.com** or by calling **1-800-795-7772**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** person / **$6,000** family per plan year for In-Network providers; **$6,000** person / **$12,000** family per plan year for Out-of-Network providers. Does not apply to: preventive care received at an In-Network Provider; first $500 for Radiology/Lab, Urgent Care Services, office visits, Allergy testing, Chiropractor	You must pay all the cost up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	"You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers."
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network providers **$3,000** person / **$6,000** family per plan year. For Out-of-Network providers **$7,000** person / **$14,000** family per plan year. Prescription drugs have a separate out-of-pocket limit of $2,000 person / $4,000 family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Prescription drug copayments, penalties for failure to obtain precertification, amounts over Usual and Customary, premiums, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.myCigna.com or call 1-800-795-7772.	"If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**."
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit Charge Only: $30 co-pay/visit All other services: 0% co-insurance	30% co-insurance	Deductible does not apply to In-Network Providers for the office visit charge only. Co-pay applies to the office visit charge only.
	Specialist visit	Office Visit Charge Only: $50 co-pay/visit All other services: 0% co-insurance	30% co-insurance	Deductible does not apply to In-Network Providers for the office visit charge only. Co-pay applies to the office visit charge only.
	Other practitioner office visit	All other services: 0% co-insurance Chiropractor: $50 co-pay/visit	30% co-insurance	Deductible applies. Chiropractic care is limited to a 20 visit plan year maximum.
	Preventive care/screening/ immunization	No Charge	No Covered	Covered Expenses include items and services rated A or B in the United States Preventive Services Task Force recommendations and services set forth in comprehensive guidelines supported by the Health Resources and Services Administration including but not limited to: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests, immunizations, well child care and other preventive care services required by applicable law. For any service that does not have a Network provider available, coverage will be provided at the In-Network level of benefits. Subject to age and frequency limits.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for first $500 per visit, then 0% co-insurance	30% co-insurance	Deductible applies.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No Charge for first $500 per visit, then 0% co-insurance	30% co-insurance	Deductible applies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com or 1-800-424-5828	Generic drugs	Retail: $10 co-pay/prescription Mail Order: $27 co-pay/prescription	Not Covered	Deductible does not apply. Covers up to a 30-day supply at a retail pharmacy and up to a 90-day supply through mail order. You are required to receive the generic drug when the generic drug is available. If you request a brand drug over a generic you will be responsible for the applicable co-pay plus the difference in cost between the brand and the generic. However, if your Physician specified "Dispense as Written", you will only pay the applicable co-pay. Certain drugs used for preventive care will be covered at no charge to you if you have a prescription. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, as required by the Affordable Care Act are covered at 100% not subject to any copayment, coinsurance or deductible. Including certain contraceptive, certain preventive drugs and certain smoking cessation products.
	Preferred brand drugs	Retail: $25 co-pay/prescription Mail Order: $67.50 co-pay/prescription	Not Covered	
	Non-preferred brand drugs	Retail: $40 co-pay/prescription Mail Order: $108 co-pay/prescription	Not Covered	
	Specialty drugs	Retail: $150 co-pay/prescription	No Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	30% co-insurance	Deductible applies.
	Physician/surgeon fees	0% co-insurance	30% co-insurance	Deductible applies.
If you need immediate medical attention	Emergency room services	0% co-insurance	0% co-insurance	Deductible applies. Emergency admissions must be reported within 48 hours after the first business days after the admission or you may be assessed a penalty.
	Emergency medical transportation	0% co-insurance	20% co-insurance	Deductible applies.
	Urgent care	Office Visit Charge Only: $50 co-pay/visit	30% co-insurance	Deductible does not apply to In-Network Providers.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-insurance	30% co-insurance	Deductible applies. Non-emergency hospital admissions must be reported as soon as possible of the admission or you may be assessed a penalty.
	Physician/surgeon fee	0% co-insurance	30% co-insurance	Deductible applies.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit Charge Only: $50 co-pay/visit All other services: 0% co-insurance	50% co-insurance	Deductible does not apply to In-Network Providers.
	Mental/Behavioral health inpatient services	0% co-insurance	50% co-insurance	Deductible applies. Emergency admissions must be reported within 48 hours after the admission and non-emergency hospital admissions must be reported as soon as possible in advance of the admission or you may be assessed a penalty.
	Substance use disorder outpatient services	Office Visit Charge Only: $50 co-pay/visit All other services: 0% co-insurance	50% co-insurance	Deductible does not apply to In-Network Providers.
	Substance use disorder inpatient services	0% co-insurance	50% co-insurance	Deductible applies. Emergency admissions must be reported within 48 hours after the admission and non-emergency hospital admissions must be reported as soon as possible in advance of the admission or you may be assessed a penalty.
If you are pregnant	Prenatal and postnatal care	0% co-insurance	30% co-insurance	Deductible applies. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.
	Delivery and all inpatient services	0% co-insurance	30% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% co-insurance	30% co-insurance	Deductible applies. Coverage is limited to a 60 visit plan year maximum.
	Rehabilitation services	0% co-insurance	30% co-insurance	Deductible applies. Speech therapy, physical therapy and occupational therapy are each limited to a 30 day plan year maximum each and up to a combination of 60 visits per plan year.
	Habilitation services	0% co-insurance	30% co-insurance	Deductible applies. Coverage is only provided for speech therapy when needed to correct a congenital anomaly (e.g. cleft lip or cleft palate).
	Skilled nursing care	0% co-insurance	30% co-insurance	Deductible applies. Skilled Nursing Facility stays must be reported to the plan at least 48 hours in advance of the stay or you may be assessed a penalty. Coverage is limited to a 60 day/visit plan year maximum. Must be received within 14 days of a 3 day Hospital stay.
	Durable medical equipment	0% co-insurance	30% co-insurance	Deductible applies.
	Hospice service	0% co-insurance	20% co-insurance	Deductible applies.
If your child needs dental or eye care	Eye exam	No Covered	No Covered	A vision screening is covered as part of your child's wellness visit with his or her family Physician. There is no coverage for an eye exam received through an Optometrist.
	Glasses	No Covered	No Covered	----------none----------
	Dental check-up	No Covered	No Covered	Oral health check-ups are covered as part of your child's wellness visit with his or her family Physician.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery,
- Dental care (Adult)
- Habilitative Services, except for speech therapy
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Habilitative services but only to correct congenital anomalies

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-795-7772. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plans' Third Party Administrator Regional Care, Inc. 1-800-795-7772 or www.regionalcare.com. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/ does not] provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-7772.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,390
- **Patient pays** $3,150

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$3,150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,320
- **Patient pays** $3,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.