




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, <https://my.centivo.com> or call 1-800-776-8243. 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.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-network provider : \$6,350/Individual or \$12,700/Family Out-of-network provider : \$19,050/Individual or \$38,100/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 deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary 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.
What is the out-of-pocket limit for this plan ?	In-network provider : \$6,350/Individual or \$12,700/Family Out-of-network provider : \$21,550/Individual or \$43,100/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 ?	Copayments for certain services, premiums , balance-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 www.hcpdirectory.cigna.com or call 1-800-776-8243 for a list of network 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 , as this plan has no out-of-network coverage, except emergency services. 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 a referral .

 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
		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	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Virtual visits and telephonic visits are the same as in-office visits.
	Specialist visit	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive Care/screening/immunization	No charge	Deductible , then 30% coinsurance	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)	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits may be reduced.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://go.withmehealth.com or call 1-866-317-1518.	Tier 1 drugs	Retail or mail order: Deductible , then 0% coinsurance	Not covered	Covers up to a 30-day supply (retail subscription); 31–90-day supply (mail order prescription). Specialty drugs are not covered under this plan. Please contact TRS at 1-866-972-0667 for information on specialty drug coverage.
	Tier 2 drugs	Retail or mail order: Deductible , then 0% coinsurance	Not covered	
	Tier 3 drugs	Retail or mail order: Deductible , then 0% coinsurance	Not covered	
	Tier 4 - Specialty drugs	Not covered Please contact TRS at 1-866-972-0667	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits may be reduced.
	Physician/surgeon fees	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://my.centivo.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)	
If you need immediate medical attention	Emergency room care	Deductible , then 0% coinsurance	In-network deductible , then 0% coinsurance	Non-emergent use of the Emergency Room is not covered. All Emergency Services are considered In Network. Air Ambulance must be medically necessary , and preauthorization is required. If you don't get preauthorization , benefits may be reduced.
	Emergency medical transportation	Deductible , then 0% coinsurance	In-network deductible , then 0% coinsurance	
	Urgent care	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits may be reduced.
	Physician/surgeon fees	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	None
	Inpatient services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Preauthorization may be required. If you don't get preauthorization , benefits may be reduced.
If you are pregnant	Office visits	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, deductible and/or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Failure to obtain preauthorization for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in benefits being reduced.
	Childbirth/delivery professional services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	
	Childbirth/delivery facility services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	

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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 need help recovering or have other special health needs	Home health care	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	90 visits/year combined with Private Duty Nursing in the home setting.
	Rehabilitation services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	25visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	
	Skilled nursing care	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	90 visits/year - Preauthorization may be required. If you don't get preauthorization , benefits may be reduced.
	Durable medical equipment	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	Deductible , then 0% coinsurance	Deductible , then 30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage limited as required by PPACA.
	Children's glasses	Not covered	Not covered	Not a covered service under this plan .
	Children's dental check-up	Not covered	Not covered	Coverage is limited to an oral risk assessment each year as required by PPACA.

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 .)		
<ul style="list-style-type: none"> • Bariatric Surgery • Cosmetic surgery • Dental care (Adult) • Hearing Aids 	<ul style="list-style-type: none"> • Infertility Treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine foot care • Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Chiropractic Care 	<ul style="list-style-type: none"> • Private Duty Nursing (in home setting)

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://my.centivo.com>.

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: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [Affordable Care Act | U.S. Department of Labor \(dol.gov\)](#) or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.CMS.gov](#). 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 on how 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: Centivo at 1-800-776-8243. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA x3272 or [dol.gov/ebsa/healthreform](#).

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet 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 1-800-776-8243.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-8243.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-776-8243.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-776-8243.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) \$6,350
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$6,350
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$6,350

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$5,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$5,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.