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, www.healthscopebenefits.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 www.cciio.cms.gov or call 1-877-385-8773 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,800** Employee **$3,600** Employee + 1 **$5,400** 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 is 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?	**HCMC** and Network: **$6,300** Employee, **$12,600** Family; Non-network: **Unlimited** **HCMC** Pharmacy: **$1,600** Employee; **$3,200** 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, HCMC pharmacy copayment, 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.healthscopebenefits.com or call 1-877-385-8773 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 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 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
		Henry County Medical Center (HCMC)	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay If office surgery: 10% coinsurance	30% coinsurance	50% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Facility 0% coinsurance Physician $45 copay	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance*	50% coinsurance*	*MRI and CT scans are covered at HCMC only, unless approved by the Plan Sponsor.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs	20% coinsurance (HCMC Pharmacy)	$10 minimum copay 50% coinsurance (Cigna Pharmacy)	Not Covered	None
	Preferred brand drugs	30% coinsurance (HCMC Pharmacy)	$10 minimum copay 60% coinsurance (Cigna Pharmacy)	Not Covered	
	Non-preferred brand drugs	40% coinsurance (HCMC Pharmacy)	$10 minimum copay 80% coinsurance (Cigna Pharmacy)	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Henry County Medical Center (HCMC)	In-Network Provider	Out-of-Network Provider	
	Specialty drugs	20% coinsurance Generic/30% coinsurance preferred/40% coinsurance non preferred (HCMC Pharmacy)	Not Covered (Cigna Pharmacy)	Not Covered	HCMC Retail Pharmacy 20% generic/30% brand.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	Not Covered	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	Emergency $25 copay 20% coinsurance Facility and Physician Services Non-Emergency $50 copay 20% coinsurance	Emergency $25 copay 20% coinsurance Facility and Physician Services Non-Emergency $50 copay 30% coinsurance	Emergency $25 copay 20% coinsurance Facility and Physician Services Non-Emergency $75 copay 50% coinsurance	Copay is waived if patient is admitted. Copay increases to $150 for 3 or more visits per calendar year.
	Emergency medical transportation	0% coinsurance	30% coinsurance	50% coinsurance	None
	Urgent care	10% coinsurance	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	$400 copay 30% coinsurance	$400 copay 50% coinsurance	Precertification is required
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Henry County Medical Center (HCMC)	In-Network Provider	Out-of-Network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility: 0% coinsurance; Physician: $45 copay	30% coinsurance	50% coinsurance	None
	Inpatient services	Facility: 0% coinsurance; Physician: 10% coinsurance	$400 copay 30% coinsurance	$400 copay 50% coinsurance	Precertification is required
If you are pregnant	Office visits	$45 copay	30% coinsurance	50% coinsurance	Precertification may be required. Covered for Employee and Spouse only; some preventive services for Dependent Children's pregnancies may be covered under the Preventive Care benefit.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	$400 copay 30% coinsurance	$400 copay 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Not Covered	None
	Rehabilitation services	0% coinsurance	Not Covered	Not Covered	In network and out of network physical, speech, and occupational therapy not covered without prior approval. This does not apply to HCMC
	Habilitation services	0% coinsurance	Not Covered	Not Covered	
	Skilled nursing care	0% coinsurance	Not Covered	Not Covered	None
	Durable medical equipment	0% coinsurance	30% coinsurance*	50% coinsurance*	*If not available at HCMC.
	Hospice services	0% coinsurance	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to screening for children under 5 as part of preventive benefit. Plans are available for vision/dental coverage.
	Children's glasses	Not Covered	Not Covered	Not Covered	Plans are available for vision/dental coverage.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Plans are available for vision/dental coverage.

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.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
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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 (limited to $1,000 maximum per calendar year)
- Hearing Aids (Children under age 18 only, 1 set every 3 years)
- Private Duty Nursing (Outpatient Only)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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: HealthSCOPE Benefits at 1-877-385-8773.

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 1-877-385-8773.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-385-8773.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-385-8773.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-385-8773.

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 HCMC pre-natal care and a hospital delivery)

The plan's overall deductible	$1,800
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
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	$1,800
Copayments	$90
Coinsurance	$7
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,957**

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

The plan's overall deductible	$1,800
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
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	$1,800
Copayments	$360
Coinsurance	$879
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,094**

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

The plan's overall deductible	$1,800
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,092
Copayments	$170
Coinsurance	$29
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,292**

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