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.online.bywaterbenefits.com or call **1-855-325-2665**. 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 1-855-325-2665** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000**/Individual or **$6,000**/family for in-network providers and **$5,000** individual/**$10,000** family for out-of-network providers.	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $6000 family; for out-of-network providers $10,000 individual / $20,000 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, amounts over Usual and Customary charges, cost containment 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. See www.mycigna.com or call **1-855-325-2665** 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 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	$30 copay; 0% after deductible	50% coinsurance	None
	Specialist visit	$50 copay; 0% after deductible	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% 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)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$200 copay; 0% after deductible	50% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.southernscripts.net	Generic drugs	First Choice: $15 copayment, after deductible (retail) Non-First Choice$15 copayment, after deductible (retail)	Not applicable	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). The following services are covered at 100% if FDA-approved and prescribed by a doctor: - Contraceptive methods for women, including OTC (such as contraceptive sponges and spermicides); - Aspirin to prevent Cardiovascular Disease (OTC); - Iron Supplementation (OTC) (for Children at increased risk for iron-deficiency anemia); - Folic Acid Supplementation (for women planning or capable of pregnancy); - Oral Fluoride Supplementation (where water source does not contain fluoride); - Smoking deterrents. A description of these services can be found at
	Preferred brand drugs **Note:** Up to max of $150 for more than 30 day supply.	First Choice: $40 copayment, after deductible (retail) Non-First Choice$40 copayment, after deductible (retail)	Not applicable	

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)	
	Non-preferred brand drugs/Compound Brand Name	First Choice: $70 copayment, after deductible (retail) Non-First Choice$70 copayment, after deductible (retail)	Not applicable	https://www.healthcare.gov/coverage/preventive-care-benefits/ Covers up to a 31-day supply. Must be purchased through Southern Scripts. If you are eligible to receive a subsidy through a manufacturer copay program, your copayment under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate towards your deductible or out-of-pocket costs. If you are receiving a prescription drug through a manufacturer free drug program and you enroll in the Manufacturer Free Drug Initiative, that drug will not be covered under the plan.
	Specialty drugs	First Choice: 50% up to a max of $250, after deductible Non-First Choice: 50% up to a max of $250, after deductible	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Precertification is required.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance		Emergency Room Care for non-emergency diagnosis for In-Network not covered
	Emergency medical transportation	0% coinsurance		
	Urgent care (Lab & Xrays) All other services provided with an office visit, except	0% coinsurance	50% coinsurance 50% coinsurance	

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)	
	surgery and allergy injections			
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Precertification is required.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay; 0% after deductible	50% coinsurance	None
	Inpatient services	$500 per day; 0% after deductible	50% coinsurance	Precertification is required. Max of 5 deductibles per year
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	60 visits/year; Precertification is required.
	Rehabilitation services	0% coinsurance	50% coinsurance	- Cardiac Rehabilitation Therapy: 36 visit max per calendar year - Physical/Occupational Therapy: 30 visit max per calendar year - Speech Therapy: 20 visit max per calendar year
	Habilitation services	0% coinsurance	50% coinsurance	
	Skilled nursing care	0% coinsurance	50% coinsurance	100 days/calendar year.
	Durable medical equipment	0% coinsurance	50% coinsurance	Requires precertification for some equipment, such as seat lefts, wheel chairs, insulin pumps, and other like equipment in order to avoid a reduction of benefits.
	Hospice services	0% coinsurance	50% coinsurance	15 days/ calendar year

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 your child needs dental or eye care	Children's eye exam	0% coinsurance	50% coinsurance	Limited to vision screening in accordance with the ACA preventive guidelines.
	Children's glasses	Not covered	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	0% coinsurance	50% coinsurance	Limited to oral health risk assessment in accordance with the ACA preventive guidelines.

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.)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care

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

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-855-325-2665. 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/healthreform, or the U.S. Department of health and Human Services at 1-877-267-2323 x61565 or www.cciio.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 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 the plan at 1-855-325-2665. You may also contact your state insurance department, the U.S. Department of health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 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 1-855-325-2665
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-325-2665
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-855-325-2665
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-325-2665

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 in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3000
Specialist copayment	$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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	$3000
Specialist copayment	$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$3000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,000**

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

The plan's overall deductible	$3000
Specialist copayment	$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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**