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, call 1-800-242-4472. 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.mygisc.com or call 1-800-242-4472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/Individual, $400/family for network providers. $500/Individual, $1000/family for out-of-network providers. Doesn't apply to preventive, prescriptions & copayments.	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. Plan is calendar year.
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 specfic services.
What is the out-of-pocket limit for this plan?	For network providers $600/ individual, $1200/family; for out-of-network providers $1500/individual, $2000/family. Prescription drug out-of-pocket limit is $1250/individual, $2500/family. Overall out-of-pocket limit for network providers $6600/individual or $13500/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. This amount includes deductible & coinsurance. Overall out-of-pocket limit includes deductible, coinsurance & copayments.
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. Copayments apply to overall out-of-pocket limit.	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.cigna.com or call 1-800-242-4472 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 **coinsurance** costs shown in this chart are after your **deductible** has been met.

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	$15 copay/office visit	30% coinsurance after deductible	None
	Specialist visit	$15 copay/visit	30% coinsurance after deductible	Includes Chiropractic Services up to 12 visits per calendar year, approval needed for additional visits; Nutritionist-network providers only
	Preventive care/screening/ immunization	No charge	30% coinsurance after deductible	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)	20% coinsurance after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance after deductible	

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.maxorplus.com	Generic drugs & Brand name if generic not available	Retail - $10 copay per 30 to 90 day supply; Mail Order - $10 copay per 90 day supply	100%	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription). Some drugs require prior authorization to be covered. Specialty drugs must be filled through MaxorPlus Specialty Pharmacy and limited to a 30 days supply. Split incentive program is available through mail order at no charge. Prescription drug out-of-pocket limit is $1250/individual or $2500/family.
	Preferred Brand	Retail - $30 copay per 30 day supply; Mail Order - $30 copay per 90 day supply	100%	
	Non -Preferred Brand drugs	Retail - $45 copay per 30 day supply; Mail Order - $45 copay per 90 day supply	100%	
	Contraception, Diabetic Drugs & Supplies	No charge	100%	
	Specialty drugs	See tier copay above	100%	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Non-Emergency visits are not covered. Copay is waived if admitted
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	$15 copay/visit	$15 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required

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 mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit	30% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required.
If you are pregnant	Office visits	$15 copay/office visit	30% coinsurance after deductible	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). Preauthorization is required for stay more than 48 hours normal delivery or 96 hours C-section
	Childbirth/delivery professional services	20% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required
	Rehabilitation services	20% coinsurance after deductible	100%	30 visits/year. Includes physical therapy, speech therapy and occupational therapy. Preauthorization is required for inpatient services
	Habilitation services	20% coinsurance after deductible	100%	
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	60 visits/calendar year. Preauthorization is required for inpatient services
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	None
	Hospice services	20% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required

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	None	None	Coverage limited to one exam/year to age 19.
	Children's glasses	None	None	Coverage limited to one pair of glasses or contacts/year to age 19.
	Children's dental check-up	None	None	Coverage limited to 2 exams/cleaning & 1 set of xrays per year to age 19.

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 (Adult)
- Hearing Aids
- Infertility Treatment
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- 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 Admiistration at 1-866-444-EBSA (3272) or www.dol.gov/egsa/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: Department of labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/egsa/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 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 1-800-242-4472.]

———————————*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	$200
■ Specialist copayment	$15
■ Hospital (facility) coinsurance	80%
■ Other coinsurance	80%

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	$200
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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

■ The plan's overall deductible	$200
■ Specialist copayment	$15
■ Hospital (facility) coinsurance	80%
■ Other coinsurance	80%

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*	$200
Copayments	$150
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$510**

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

■ The plan's overall deductible	$200
■ Specialist copayment	$15
■ Hospital (facility) coinsurance	80%
■ Other coinsurance	80%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$190
Coinsurance	$302
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$692**

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