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 844-682-1545 or visit www.showmeadmin.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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 844-682-1545 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network:** **$3,000** Individual / **6,000** Family **Non-Network:** **$9,000** Individual / **$18,000**	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 the deductible expenses paid by all family members meets the overall family deductible. **Accrual period is calendar year (Jan 1 - Dec 31).**
Are there services covered before you meet your deductible?	Family Network Provider: Preventive Care	The 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?	**Network:** **$5,500** Individual / **$11,000** Family **Non-Network:** **$11,000** Individual / **$22,000** 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 limits until the overall family out-of-pocket limit has been met. **Accrual period is calendar year (Jan 1 - Dec 31).**
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), penalties for failure to obtain pre-certification 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.** Cigna Network. To locate a provider visit www.cigna.com .	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
		Network Provider (You will pay the least)	Non-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	$25 copay per visit deductible waived	50% coinsurance after deductible	**Office Surgery and Anesthesia, Therapeutic Injections, Allergy Injections and Serum, X-ray, Diagnostic Testing, Telemedicine and All Other Office Related Services:** Office surgeries limit 2 per Calendar Year then Ded/Coins. Network Provider: PCP $25 copay deductible waived Specialist $35 copay deductible waived Non-Network Provider: 50% coinsurance after deductible **Allergy Injections & Serum (FDA approved):** Given at provider's office- PCP or SP copay applies **Allergy Testing:** Deductible applies / PCP or SP copay will also apply if billed with office visit **Lab:** Network Provider: $0 copay Non-Network Provider: 50% coinsurance after deductible
	Specialist visit	$35 copay per visit deductible waived	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible	Benefits are available for evidence based items or services that have in effect a rating "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). http://www.uspreventiveservicestaskforce.org. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test	Outpatient X-ray: 20% coinsurance after deductible Outpatient Lab: $0 copay	Outpatient X-ray and Lab: 50% coinsurance after deductible	Independent Lab: Network Provider: $0 copay Non-Network Provider: 50% coinsurance after deductible

	Imaging	20% coinsurance after deductible	50% coinsurance after deductible	CT/PET scans, MRIs Pre-certification is required, call 844-682- 1545. Failure to pre-certify will result in a penalty of $250.
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, & Other Important Information**
		Network Provider (You will pay the least)	**Non-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.savrx.com or call Sav-RX at 800-228-3108.	Generic drugs	$10 copay deductible waived	$10 copay deductible waived	Retail - 30 day supply - copay applies to each 30 day supply. Mail Order - copay applies to each 31-90 day supply. Specialty Drug Program: Specialty Medications are an excluded class of Medication. Please contact Show-Me Health Administrators for further details - as in some instances your physician can assist you with receiving your medication through the Manufacturers/Patient Assistance programs.
	Preferred brand drugs	$35 copay deductible waived	$35 copay deductible waived	
	Non-preferred brand drugs	$60 copay deductible waived	$60 copay deductible waived	
	Specialty drugs	Excluded		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None.
	Emergency room care	$200 copay deductible waived	$200 copay deductible waived	If admitted within 24 hours, copay waived, and pre-cert required. Call 844-682-1545. Failure to pre-certify will result in a penalty of $250.

If you need immediate medical attention	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible (network deductible and out-of-pocket apply)	Ambulance (Air, Water, and Ground Transfers for non-emergency): Pre-certification is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Urgent care	$50 copay deductible waived	50% coinsurance after deductible	Charges for certain diagnostic procedures such as MRI, PET, BONE Scan, Cardiac Stress Test, Radiation, Chemo, Dialysis, CT Scan are subject to deductible/coinsurance.
Common Medical Event	**Services You May Need**	**What You Will Pay** **Network Provider** **(You will pay the least)**	**Non-Network Provider** **You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25 copay per visit deductible waived Outpatient Services: 20% coinsurance after deductible	Office Visit/Outpatient Services: 50% coinsurance after deductible	Outpatient Services: Pre-certification is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
If you are pregnant	Office visits (first visit to diagnose pregnancy)	$25 copay per visit deductible waived	50% coinsurance after deductible	Cost sharing does not apply for certain Network Prenatal/Preventive services required by PPACA. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	

	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required for inpatient stays longer than 48 hours for vaginal delivery or 72 hours for cesarean delivery, call 844-682-1545. Failure to pre-certify will result in a penalty of $250 per admission.
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, & Other Important Information**
		Network Provider (You will pay the least)	**Non-Network Provider You will pay the most)**	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 60 visits per calendar year. Pre-cert is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Rehabilitation services	$35 copay deductible waived	50% coinsurance after deductible	Physical Therapy, Occupational Therapy, Speech Therapy, Therapeutic Massage, and all other covered services: Pre-cert is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250. Maximum benefits per calendar year 40 visits per therapy.
	Habilitation services	$35 copay deductible waived	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 days per calendar year. Pre-cert is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required call 844-682-1545. Failure to pre-certify will result in a penalty of $250.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-cert is required, call 844-682-1545. Failure to pre-certify will result in a penalty of $250. Bereavement counseling covered within 6 months of death.
	Children's eye exam	$35 copay deductible waived	50% coinsurance after deductible	Up to Age 19. Limited to 1 routine eye exam per Calendar Year.

If your child needs dental or eye care	Children's glasses	20% coinsurance after deductible	50% coinsurance after deductible	Up to Age 19.
	Children's dental check-up	No charge	50% coinsurance after deductible	Up to Age 5. Coverage limited to oral health risk assessment 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.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental	• Infertility treatment • Long-term 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 – calendar year maximum of 26 visits	• Diabetic Shoes – Limited to 2 pair per calendar year (paid In-Network)	• Hearing aids - one aid per ear each 36-month period

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 available by calling 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. 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: 844-682-1545. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/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 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.

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	$3,000
PCP copay	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$25
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,910**

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

The plan's overall deductible	$3,000
Specialist copay	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$3,000
Copayments	$295
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,696**

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

The plan's overall deductible	$3,000
Specialist copay	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$951
Copayments	$495
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,618**

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