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.myqhresource.com or call 1-866-885-1493. For 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/healthreform and www.cciio.cms.gov or call 1-800-877-1122 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Hospitals: $750 individual/$2,250 family network, Cigna OAP Network: $3,500 individual/$10,500 family Non-Network: Not covered	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 (embedded) 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 not subject to deductible.	This plan covers some items and services even if you haven't 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 http://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	Preferred Hospitals: $6,850 individual/$13,700 family, Cigna OAP Network: $6,850 individual/$13,700 family, Non-Network: Not covered, medical and pharmacy combined.	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 (embedded) until the overall family out-of-pocket limits has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balanced billing is prohibited), 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.myqhresource.com or call 1-866-885-1493 for a list of network providers.	You will pay less if you use a provider in the plan's network. Out of network services are not covered. 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	Preferred Hospitals	Cigna OAP Network	Out of –Network	Limitations & Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	$20 copayment/visit deductible waived		Not covered	Copayment applies to all charges billed for the office service. Including, but not limited to, diagnostic lab, office surgery, diagnostic miscellaneous testing and allergy injections. Additional charges not performed during the office visit are subject to deductible and coinsurance.
	Specialist (SCP) visit	$40 copayment/visit deductible waived		Not covered	
	Preventive care/screening/ immunization	No charge deductible waived		Not covered	You may have to pay for services that are not 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 (x-ray, blood work)	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**.	Generic drugs	Low Plan Option: $10 copayment 1-30 day supply retail $20 copayment 31-90 day supply mail order High Plan Option: $10 copayment 1-30 day supply retail $20 copayment 31-90 day supply mail order			Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Deductible and copayment waived for Maintenance Therapy Drugs. Coverage is limited to 30 day supply for retail; 90 day supply for mail order. Deductible may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill.
	Preferred brand drugs	Low Plan Option: 40% copayment ($20 min/$150 max) 1-30 day supply retail 40% copayment ($40 min/$300 max) 31-90 day supply retail High Plan Option: 25% copayment ($20 min/$100 max) 1-30 day supply retail 25% copayment ($40 min/$200 max) 31-90 day supply retail			
	Non-preferred brand drugs	Low Plan Option: 50% copayment ($40 min/$300 max) 1-30 day supply retail 50% copayment ($80 min/$600 max) 31-90 day supply retail High Plan Option: 40% copayment ($40 min/$300 max) 1-30 day supply retail 40% copayment ($80 min/$400 max) 31-90 day supply retail			
	Specialty drugs	Low Plan Option: Generic: $10 copayment Preferred Brand: 40% copayment ($20 min/$150 max) Non-Preferred Brand: 50% copayment ($40 min/$300 max) High Plan Option: Generic: $10 copayment Preferred Brand: 25% copayment ($20 min/$100 max) Non-Preferred Brand: 40% copayment ($40 min/$300 max)			Specialty prescriptions must be obtained from a specialty pharmacy. Specialty drugs under the PrudentRx program are covered at 30% coinsurance. Coverage limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	None

For more information about limitations and exceptions, see the plan or policy document at www.myqhresource.com or call 1-866-885-1493.

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	Preferred Hospitals	Cigna OAP Network	Out of –Network	Limitations & Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$200 copayment then 10% coinsurance after Preferred Hospital deductible			None
	Emergency medical transportation	Air & Ground: No charge deductible waived			None
	Urgent care	$25 copayment/visit deductible waived		Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Office visits	$20 copayment/visit, deductible waived		Not covered	None
	Outpatient services	10% coinsurance after deductible		Not covered	Outpatient professional provider services subject to $20 copayment deductible waived.
	Inpatient services	10% coinsurance after deductible		Not covered	Inpatient services for mental health are subject to preauthorization. Inpatient professional provider services subject to applicable coinsurance and deductible.
If you are pregnant	Office visits	$20 copayment for initial visit or if billed per office visit, no cost for additional visits		Not covered	Inpatient maternity services exceeding 48 hours vaginal delivery or 96 hours C-Section are subject to preauthorization. Cost sharing does not apply for preventive services. Depending on the type of services, deductible and coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge deductible waived if billed as global fee		Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	70% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible		Not covered	Home health care services are subject to preauthorization. Coverage limited to 100 visits.
	Rehabilitation services	$20 copayment/visit deductible waived	$40 copayment/visit deductible waived	Not covered	60 visits combined for physical therapy and speech therapy.
	Habilitation services	Not covered	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance after deductible		Not covered	Skilled nursing facility services are subject to preauthorization. Coverage limited to 60 days per calendar year.
	Durable medical equipment	10% coinsurance after deductible		Not covered	Durable medical equipment is subject to preauthorization for charges exceeding $1,000. Repair or replacement of DME limited to once every 3 benefit periods.
	Hospice services	10% coinsurance after deductible		Not covered	Includes bereavement counseling. Hospice care services are subject to preauthorization.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

For more information about limitations and exceptions, see the plan or policy document at www.myqhresource.com or call 1-866-885-1493.

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)	• Long-term care • Non-emergency care when traveling outside of the U.S.	• Private-duty nursing • 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.)		
• Acupuncture (limits apply) • Bariatric surgery	• Chiropractic care (limits apply) • Hearing aids (limits apply)	• Infertility treatment (limits apply)

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: 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.cciio.cms.gov, www.myqhresource.com or call 1-866-885-1493. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.cciio.cms.gov/programs/consumer/capgrants/index.html.

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 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.

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For more information about limitations and exceptions, see the plan or policy document at www.myqhresource.com or call 1-866-885-1493.

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	$750
Specialist copayment	$40
Hospital (facility) coinsurance	10%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,020**

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	10%
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,470**

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

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	10%
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html **used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.**