



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 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 1-800-877-1122 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 network , 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.	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 network , Cigna OAP Network: \$6,850 individual/\$13,700 family network , 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-limit 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 the applicable deductible and coinsurance or copayment . 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.
	Specialist (SCP) visit	\$40 copayment /visit deductible waived		Not covered	
	Preventive care/screening/immunization	No charge deductible waived		Not covered	
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. Deductible may not apply to preventive care prescription drugs as outlined in the Affordable Care Act (PPACA). Certain prescription drugs require preauthorization before the prescription drug can be dispensed or before obtaining a second fill.
	Preferred brand drugs	Low Plan Option: 40% coinsurance (\$20 min/\$150 max) 1-30 day supply retail 40% coinsurance (\$40 min/\$300 max) 31-90 day supply mail order High Plan Option: 25% coinsurance (\$20 min/\$100 max) 1-30 day supply retail 25% coinsurance (\$40 min/\$200 max) 31-90 day supply mail order			
	Non-preferred brand drugs	Low Plan Option: 50% coinsurance (\$40 min/\$300 max) 1-30 day supply retail 50% coinsurance (\$80 min/\$600 max) 31-90 day supply mail order High Plan Option: 40% coinsurance (\$40 min/\$300 max) 1-30 day supply retail 40% coinsurance (\$80 min/\$400 max) 31-90 day supply mail order			



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Common Medical Event	Services You May Need	Preferred Hospitals	Cigna OAP Network	Out of –Network	Limitations & Exceptions & Other Important Information
	Specialty drugs	\$0 copayment if enrolled in PrudentRx. 30% coinsurance if not enrolled in PrudentRx			Specialty drugs must be obtained from a specialty pharmacy. 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
If you need immediate medical attention	Emergency room care	\$200 copayment then, 10% coinsurance after Preferred Hospitals 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	Outpatient services	Office visits: \$20 copayment /visit deductible waived		Not covered	Behavioral health visits through 24/7 virtual visit platforms will now be available at no cost on all medical plan options.
	Inpatient services	10% coinsurance after deductible		Not covered	Inpatient services for mental health are subject to preauthorization . Inpatient professional provider services subject to applicable deductible and coinsurance or copayment
If you are pregnant	Office visits	\$20 copayment for initial visit, then no cost for additional visits		Not covered	Inpatient maternity services exceeding 48 hours vaginal delivery or 96 hours C-Section



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Common Medical Event	Services You May Need	Preferred Hospitals	Cigna OAP Network	Out of –Network	Limitations & Exceptions & Other Important Information
	Childbirth/delivery professional services	10% coinsurance after deductible		Not covered	are subject to preauthorization . Cost sharing does not apply for preventive care 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 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 care 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 durable medical equipment limited to once every 3 benefit periods.
	Hospice services	10% coinsurance after deductible		Not covered	Includes bereavement counseling. Hospice 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

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](#).)

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|--|--|--|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside of the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Routine eye care (Adult)• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none">• Acupuncture (limits apply)• Bariatric surgery | <ul style="list-style-type: none">• Chiropractic care (limits apply)• Hearing aids (limits apply) | <ul style="list-style-type: none">• Infertility treatment (limits apply) |
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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 Health and Human Services at <https://www.cms.gov/marketplace/about/oversight> or call 1-888-393-2789. 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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, visit www.myqhresource.com or call 1-866-885-1493. Additionally, a consumer assistance program can help file your [appeal](#). Contact information for a consumer assistance program is located at <https://www.cms.gov/ccio/resources/consumer-assistance-grants>.

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-999-1062.

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	\$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
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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
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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
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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