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, www.iaatpa.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.iaatpa.com or call **1-856-470-1200** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$0** Out-of-network: **$300**/individual; **$500**/family	In-network: See the Common Medical Events chart below for your costs for in-network services this plan covers. Out-of-network: Generally, you must pay all of the costs from out-of-network 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.	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 specific services.
What is the out-of-pocket limit for this plan?	**$5,000** individual / **$10,000** family for Participating Providers and **$7,000** individual / **$15,000** family for Non Participating Providers. Rx Only; **$1,600** individual / **$3,200** 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.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, cost containment penalties, and healthcare 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 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

Important Questions	Answers	Why This Matters:
		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 want 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; deductible waived	20% coinsurance after deductible	——————None——————
	Specialist visit	$30 copay; deductible waived	20% coinsurance after deductible	——————None——————
	Preventive care/screening/ immunization	Covered 100%; deductible waived	Covered 100%; deductible waived	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 (x-ray, blood work)	Covered 100%; deductible waived	20% coinsurance after deductible	——————None——————
	Imaging (CT/PET scans, MRIs)	$150 copay; deductible waived	20% coinsurance after deductible	——————None——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.iaatpa.com**	Generic drugs	$15 copay/prescription - Retail 30 day. $25 copay/prescription - Retail 90 day. $15 copay/prescription - Mail order 90 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.
	Preferred brand drugs	$30 copay/prescription - Retail 30 day. $50 copay/prescription - Retail 90 day. $40 copay/prescription - Mail order 90 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.
	Non-preferred brand drugs	$70 copay/prescription - Retail 30 day.	Not covered.	Retail limit: 30-90-day supply. Mail order limit: 90-day supply.

* For more information about limitations and exceptions, see the plan or policy document at www.iaatpa.com

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)	
		$100 copay/prescription -Retail 90 day. $85 copay/prescription - Mail order 90 day.		
	Specialty drugs	$70 copay/prescription - Retail 30 day.	Not covered.	Essential specialty medications are provided by CapitalRX through "Costco – Specialty Pharmacy," while non-essential specialty medications are not covered. For questions on essential specialty drugs please call 833-752-2779, and for assistance with non-essential specialty drugs contact Care Advocates at 844-922-7795.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay; deductible waived	20% coinsurance after deductible	——————None——————
	Physician/surgeon fees	Covered 100%; deductible waived	20% coinsurance after deductible	——————None——————
If you need immediate medical attention	Emergency room care	$125 copay; deductible waived	Paid at the In-Network level of benefits	Copay waived if admitted
	Emergency medical transportation	$30 copay; deductible waived	Paid at the In-Network level of benefits	For Emergency Transportation only
	Urgent care	$50 copay; deductible waived	20% coinsurance after deductible	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day; deductible waived	20% coinsurance after deductible	Pre-certification required. The copay $100 copay is for a maximum of five days or $500 maximum per Calendar Year (Individual) or $1,000 maximum per Calendar Year (family).
	Physician/surgeon fees	Covered 100%; deductible waived	20% coinsurance after deductible	——————None——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay; deductible waived	20% coinsurance after deductible	——————None——————
	Inpatient services	$100 copay per day; deductible waived	20% coinsurance after deductible	Pre-certification required. The copay $100 copay is for a maximum of five days or $500 maximum per Calendar Year (Individual) or

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)	
				$1,000 maximum per Calendar Year (family).
If you are pregnant	Office visits	$30 copay; deductible waived	20% coinsurance after deductible	——————None——————
	Childbirth/delivery professional services	Covered 100%; deductible waived	20% coinsurance after deductible	Employee and Spouse. Pre-natal Care only for Dependent Children.
	Childbirth/delivery facility services	$100 copay per day; deductible waived	20% coinsurance after deductible	Pre-certification required. Employee and Spouse. Pre-natal Care only for Dependent Children. The copay $100 copay is for a maximum of five days or $500 maximum per Calendar Year (Individual) or $1,000 maximum per Calendar Year (family).
If you need help recovering or have other special health needs	Home health care	$30 copay; deductible waived	20% coinsurance after deductible	Pre-certification required. Limited to 120 visit maximum per Calendar Year.
	Rehabilitation services	$30 copay; deductible waived	20% coinsurance after deductible	Physical and Speech therapy are covered 100% after a $5 copay for In-Network. Physical therapy is limited to 30 visits per Calendar Year combined with Chiropractic Care. Occupational and Speech therapy are limited to 30 visits per Calendar Year.
	Habilitation services	Not Covered		
	Skilled nursing care	$100 copay per day; deductible waived	20% coinsurance after deductible	Pre-certification required. The copay $100 copay is for a maximum of five days or $500 maximum per Calendar Year (Individual) or $1,000 maximum per Calendar Year (family).
	Durable medical equipment	$30 copay; deductible waived	20% coinsurance after deductible	New device once every two consecutive years.
	Hospice services	Covered 100% after a one time $100 copay	20% coinsurance after deductible	——————None——————
If your child needs dental or eye care	Children's eye exam	$200 allowance		One in 12 months. Amount and frequency limitations do not apply to any covered child(ren) who are under the age of 19.
	Children's glasses	Single Vision: $200 allowance		One pair of prescription plastic or glass

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)	
		Bifocal: $240 allowance Trifocal: $250 allowance		lenses in 12 months.
	Children's dental check-up	Please see separate dental plan for benefits.		

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.)

- Bariatric surgery
- Long term care
- Routine Foot Care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Cosmetic surgery
- Private Duty Nursing

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

- Acupuncture (30 visits per Calendar Year)
- Hearing Aids
- Chiropractic care
- Infertility treatment
- Dental Care (Adult)—Covered under separate dental plan.
- 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: 1-856-470-1200. 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, contact: 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**..

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 1-888-808-9008.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-808-9008.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-808-9008.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-808-9008.

* For more information about limitations and exceptions, see the plan or policy document at www.iaatpa.com

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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** **$0**
- **Specialist** **$30**
- **Hospital (facility)$100 copay per day for maximum of 5 days**
- **Other** **100%**

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

- **The plan's overall deductible** **$0**
- **Specialist** **$30**
- **Hospital (facility)$100 copay per day for maximum of 5 days**
- **Other** **100%**

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

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

- **The plan's overall deductible** **$0**
- **Specialist** **$30**
- **Hospital (facility)$100 copay per day for maximum of 5 days**
- **Other** **100%**

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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