**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 Customer Service at 1-877-601-3835 or visit www.myhealth360piedmont.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 https://www.healthcare.gov/sbcglossary or call 1-877-601-3835 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For Tier 1 network providers **$1,500** individual **/or $3,000** family. For Tier 2 network providers **$3,000** individual **/or $6,000** family. For out-of-network providers **$3,000** person **/$6,000** family. | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive 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 covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $150 prescription drug coverage. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For Tier 1 network providers **$3,500** individual **/or $6,850** family. For Tier 2 network providers **$6,850** individual **/or $13,700** family. For out-of-network providers **$10,000** individual **/or $20,000** 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 must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, 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.myhealth360piedmont.com or call 1-877-601-3835 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 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 Tier 1 (You will pay the least) | Network Provider Tier 2 (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 | $20 copay/visit | $20 copay/visit | 50% coinsurance | None |
| | Specialist visit | $70 copay/visit | 30% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge | No charge | Not covered | 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) | No charge for independent and outpatient labs; 10% coinsurance for x-rays | No charge for independent labs; 30% coinsurance for outpatient labs | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.myhealth360piedmont.com | Preventive Generic drugs ** | $0 copay for 30 day supply (retail); $0 copay for 90 day supply (mail) | $0 copay for 30 day supply (retail); $0 copay for 90 day supply (mail) | Not covered | $150 annual deductible for brand-name prescriptions (preferred & non-preferred)<br>** Specific preventive Generic medication list as posted on: www.myhealth360piedmont.com<br>Coverage is limited to a 90-day supply through Cigna Home Delivery. 30-day supply (Cigna Pharmacy Network). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. |
| | Generic drugs | $10 copay for 30 day supply (retail); $25 copay for 90 day supply (mail) | $10 copay for 30 day supply (retail); $25 copay for 90 day supply (mail) | Not covered | |
| | Preferred Brand Name drugs | $40 copay for 30 day supply (retail); $100 copay for 90 day supply (mail) | $40 copay/visit for 30 day supply (retail); $100 copay for 90 day supply (mail) | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider Tier 1 (You will pay the least) | Network Provider Tier 2 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Non-preferred Brand Name drugs | $80 copay for 30 day supply (retail); $200 copay for 90 day supply(mail) | $80 copay for 30 day supply (retail); $200 copay for 90 day supply(mail) | Not covered | |
| | Maintenance Medication: Preventive Generic | $0 copay for 30 day supply; $0 copay for 90 day supply (retail 90 Now Pharmacy) | $0 copay for 30 day supply; $0 copay for 90 day supply (retail 90 Now Pharmacy) | Not covered | Cigna 90 Now designated pharmacies including: Piedmont Athens Regional, Oconee Drugs, Walgreens, Kroger, Walmart Pharmacies and independent pharmacies listed as 90 Now in mycigna.com |
| | Maintenance Medication: Generic | $10 copay for 30 day supply; $20 copay for 90 day supply (retail 90 Now Pharmacy) | $10 copay for 30 day supply; $20 copay for 90 day supply (retail 90 Now Pharmacy) | Not covered | |
| | Maintenance Medication: Preferred Brand Name | $40 copay for 30 day supply; $80 copay for 90 day supply (retail 90 Now Pharmacy) | $40 copay for 30 day supply; $80 copay for 90 day supply (retail 90 Now Pharmacy) | Not covered | |
| | Maintenance Medication: Non-Preferred Brand Name | $80 copay for 30 day supply; $160 copay for 90 day supply (retail 90 Now Pharmacy) | $80 copay for 30 day supply; $160 copay for 90 day supply (retail 90 Now Pharmacy) | Not covered | |
| | Specialty drugs | $150 copay for 30 day supply (retail or mail) | $150 copay for 30 day supply (retail or mail) | Not covered | $150 copay for 30 day supply only via Piedmont Specialty pharmacies including Athens Regional and Cigna Home Delivery (mail) |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider Tier 1 (You will pay the least) | Network Provider Tier 2 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | 10% coinsurance | None |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | $20 copay/visit | $50 copay/visit | $50 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not available | $20 copay/visit | 50% coinsurance | None |
| | Inpatient services | Not available | 10% coinsurance | 50% coinsurance | None |
| **If you are pregnant** | Office visits | No charge | 30% coinsurance | 50% coinsurance | Primary Care of Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductibles may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No charge | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | $750 copay/visit | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | Not available | 30% coinsurance | 50% coinsurance | Coverage is limited to 100 days annual max. Preauthorization is required. (The limit is not applicable to mental health and substance use disorder conditions.) |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Network Provider Tier 1 (You will pay the least) | Network Provider Tier 2 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | $20 copay/visit | $20 copay/visit | 50% coinsurance | Coverage is limited to 60 days annual max combined for Physical and Occupational therapies. 26 days annual max for Speech therapy.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | $20 copay/visit | $20 copay/visit | 50% coinsurance | Coverage is limited to 60 days annual max combined for Physical and Occupational therapies. 26 days annual max for Speech therapy. |
| | Skilled nursing care | Not available | 30% coinsurance | 50% coinsurance | Coverage is limited to 60 days annual max. Preauthorization is required. |
| | Durable medical equipment | 10% coinsurance | 10% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Hospice services | Not available | 30% coinsurance | 50% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye exam (Children)
- 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 (10 visits calendar year)
- Bariatric surgery ($20k LTM)
- Chiropractic Care (20 visits calendar year)
- Hearing aids

**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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/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: Customer Service at 1-877-601-3835 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (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.

**Language Access Services:**
[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-883-2422.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-883-2422.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-883-2422.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-883-2422.

*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 | $1,500 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 30% |

**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** | **$7,540** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $750 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$750** |

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 30% |

**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** | **$5,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $80 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $80 |
| **The total Joe would pay is** | **$1,720** |

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 30% |

**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 | $250 |
| Copayments | $90 |
| Coinsurance | $91 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$431** |

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