

 **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 1-877-396-1750. 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/healthreform or call 1-877-396-1750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250/Individual or \$500/family Does not apply to wellness benefits.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You do not have to meet a <u>deductible</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$1,250 individual / \$2,500 family; for <u>out-of-network providers</u> no limit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.cignasharedadministration.com or call 1-800-768-4695 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without permission from this <u>plan</u> .

Questions: Call 1-503-460-5250 or 1-877-396-1750 or visit us at www.wcearthart.com.
 For ERISA information contact DOL at www.dol.gov/ebsa/healthreform or call 1-866-444-EBSA (3272).

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 have a hospital stay	Facility fee (e.g., hospital room)	\$50 <u>copay</u> 20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for inpatient services. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	\$50 <u>copay</u> 20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$50 <u>copay</u> 20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Custodial care not covered
	Rehabilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Habilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Durable medical equipment	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	Children's eye exam	\$0 <u>copay</u>	Plan covers up to \$35	Coverage limited to one exam/year.
If your child needs dental or eye care	Children's glasses	\$0 <u>copay</u> frame allowance \$130	Plan covers per schedule	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	Not covered	Two visits per year

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** \$250
- **Specialist copayment** \$0
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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 \$12,800

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$70
Coinsurance	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$1,720

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

- **The plan's overall deductible** \$250
- **Specialist copayment** \$0
- **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:

<i>Cost Sharing</i>	
Deductibles*	\$250
Copayments	\$400
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$80
The total Joe would pay is	\$1,170

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

- **The plan's overall deductible** \$250
- **Specialist copayment** \$0
- **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 \$1,900

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$250
Copayments	\$0
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$580

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-396-1750.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.