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.dgb-online.com or call **1-888-322-2524** ext 412. 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.dgb-online.com or call 1-888-322-2524 ext 412 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: **$2,500** person / **$5,000** family Non-PPO: **$5,000** person / **$10,000** family All deductibles are per plan year.	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 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. PPO Preventive care services and PPO Prenatal & Preconception care 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 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?	PPO: **$7,500** person / **$15,000** family Non-PPO: **$10,000** person / **$20,000** family Out-of-Pocket Limits are per plan year.	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, penalties for failure to obtain preauthorization, 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, Cigna. See www.cigna.com **or call 1-888-322-2524** 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 a 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 (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	$50 copay/visit; deductible does not apply	40% coinsurance*	Includes Office Surgery, bloodwork and x-rays done in and billed by the office at time of visit.
	Specialist visit	$75 copay/visit; deductible does not apply	40% coinsurance*	Includes Office Surgery, bloodwork and x-rays done in and billed by the office at time of visit. Chiropractic care 20 visits per plan year.
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance*	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)	Primary Care Physician's Office: $50 copay/visit; deductible does not apply Specialist's Office: $75 copay/ visit; deductible does not apply Outpatient Hospital: $200 copay/visit; deductible does not apply Free Standing Facility: $50 copay/visit; deductible does not apply	40% coinsurance*	If Lab and X-rays are performed in the office on the same day as an office visit, only one copay will apply.
	Imaging (CT/PET scans, MRIs)	Hospital based: $300 copay/visit; deductible does not apply Free Standing Facility/Office: $100 copay/visit; deductible does not apply	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.

***After Deductible**

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	$10 copay*/prescription (retail) $25 copay*/prescription (mail)	No coverage	Covers 90 day supply retail prescription (3 retail copays apply).
	Preferred brand drugs	$40 copay*/prescription (retail) $100 copay*/prescription (mail)	No coverage	
	Non-preferred brand drugs	50% coinsurance up to $750 maximum*	No coverage	
	Specialty/Biotech drugs	50% coinsurance up to $750 maximum*	No coverage	Preauthorization is required. If you don't get preauthorization, there will be no coverage. Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance*	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$200 copay/visit; deductible does not apply	$200 copay/visit; deductible does not apply	None
	Emergency medical transportation	$500 copay/trip; deductible does not apply	$500 copay/trip; deductible does not apply	Professional local ambulance to & from nearest hospital.
	Urgent care	$75 copay/visit; deductible does not apply	40% coinsurance*	None

***After Deductible**

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $50 copay/visit; deductible does not apply Partial Hospitalization: 20% coinsurance*	40% coinsurance*	None
	Inpatient services	20% coinsurance*	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
If you are pregnant	Office visits	Prenatal/Preconception: No charge; deductible does not apply Postnatal: No charge; deductible does not apply	40% coinsurance*	None
	Childbirth/delivery professional services	20% coinsurance*	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Childbirth/delivery facility services	20% coinsurance* Well newborn: 20% coinsurance; deductible does not apply	40% coinsurance*	

***After Deductible**

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 need help recovering or have other special health needs	Home health care	20% coinsurance*	40% coinsurance*	90 visits per plan year. Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Rehabilitation services	$50 copay/visit; deductible does not apply	40% coinsurance*	Physical, Speech, and Occupational therapy 60 visits per plan year combined. Developmental delay, education & training excluded.
	Habilitation services			
	Skilled nursing care	20% coinsurance*	40% coinsurance*	90 days per plan year. Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Durable medical equipment	20% coinsurance*	40% coinsurance*	Preauthorization is required for Select DME. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
	Hospice services	20% coinsurance*	40% coinsurance*	Preauthorization is required. If you don't get preauthorization, there is a penalty of 20% up to a maximum of $500.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	40% coinsurance*	1 per plan year.
	Children's glasses	Not covered	Not covered	Vision coverage is available as a separate option.
	Children's dental check-up	Not covered	Not covered	Dental coverage is available as a separate option.

***After Deductible**

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
- Cosmetic Surgery
- Dental Care (Dental coverage is available as a separate option)
- Infertility Treatment
- Long-term Care
- 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
- Chiropractic Care (20 visits per plan year)
- Hearing Aids (1 per ear, every 24 months)
- Most non-elective services provided outside the United States.
- Routine Eye Care

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: Department of Labor's 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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.

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	$2,500
Specialist copayment	$75
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,270**

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

The plan's overall deductible	$2,500
Specialist copayment	$75
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$800
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,370**

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

The plan's overall deductible	$2,500
Specialist copayment	$75
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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