



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 <u>deductible</u> ?	<table><tr><td>PPO</td><td>Non-PPO</td></tr><tr><td>\$3,000 person</td><td>\$5,000 person</td></tr><tr><td>\$6,000 family</td><td>\$10,000 family</td></tr></table> All <u>deductibles</u> are per plan year.	PPO	Non-PPO	\$3,000 person	\$5,000 person	\$6,000 family	\$10,000 family	Generally, you must pay all of the costs from <u>providers</u> 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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
PPO	Non-PPO							
\$3,000 person	\$5,000 person							
\$6,000 family	\$10,000 family							
Are there services covered before you meet your <u>deductible</u> ?	Yes. PPO <u>Preventive</u> care services, PPO Prenatal/Preconception and Postnatal care 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.						
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<table><tr><td>PPO</td><td>Non-PPO</td></tr><tr><td>\$5,000 person</td><td>\$10,000 person</td></tr><tr><td>\$10,000 family</td><td>\$20,000 family</td></tr></table> <u>Out-of-Pocket Limits</u> are per plan year.	PPO	Non-PPO	\$5,000 person	\$10,000 person	\$10,000 family	\$20,000 family	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 limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
PPO	Non-PPO							
\$5,000 person	\$10,000 person							
\$10,000 family	\$20,000 family							
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , 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 <u>network provider</u> ?	Yes, Cigna. See www.cigna.com or call 1-888-322-2524 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 <u>plan's 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 <u>provider's</u> 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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see a <u>specialist</u> you choose without a <u>referral</u> .						



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	Includes Office Surgery, bloodwork and x-rays done in and billed by the office at time of visit.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	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.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Primary Care Physician's Office: \$25 <u>copay</u> /visit; <u>deductible</u> does not apply Specialist's Office: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply Outpatient Hospital: \$200 <u>copay</u> /visit; <u>deductible</u> does not apply Free Standing Facility: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	If Lab and X-rays are performed in the office on the same day as an office visit, only one <u>copay</u> will apply.
	Imaging (CT/PET scans, MRIs)	Hospital based: \$300 <u>copay</u> /visit; <u>deductible</u> does not apply Free Standing Facility/Office: \$100 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , 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 <u>prescription drug coverage</u> is available at www.proactrx.com	Generic drugs	\$10 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply \$25 <u>copay</u> /prescription (mail); <u>deductible</u> does not apply	No coverage	Covers 90-day supply retail prescription (3 retail <u>copays</u> apply).
	Preferred brand drugs	\$40 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply \$100 <u>copay</u> /prescription (mail); <u>deductible</u> does not apply	No coverage	
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply \$150 <u>copay</u> /prescription (mail); <u>deductible</u> does not apply	No coverage	
	Specialty/Biotech drugs	50% <u>coinsurance</u> up to \$750 maximum; <u>deductible</u> does not apply	No coverage	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , 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% <u>coinsurance</u> *	40% <u>coinsurance</u> *	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> *	20% <u>coinsurance</u> after PPO <u>deductible</u>	None
	<u>Emergency medical transportation</u>	\$300 <u>copay</u> /trip; <u>deductible</u> does not apply	\$300 <u>copay</u> /trip; <u>deductible</u> does not apply	Professional local ambulance to & from nearest hospital.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	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% <u>coinsurance</u> *	40% <u>coinsurance</u> *	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , 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: \$25 <u>copay</u> /visit; <u>deductible</u> does not apply Partial Hospitalization: 20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
	Inpatient services	20% <u>coinsurance</u> *		<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
If you are pregnant	Office visits	Prenatal/Preconception: No charge; <u>deductible</u> does not apply Postnatal: No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	None
	Childbirth/delivery professional services	20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	<u>Preauthorization</u> is required if stay exceeds 48 hours normal delivery/96 hours cesarean. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
	Childbirth/delivery facility services	20% <u>coinsurance</u> * Well newborn: 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	

*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	<u>Home health care</u>	20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	90 visits per plan year. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	Physical, Speech and Occupational Therapy 60 visits per plan year combined.
	<u>Habilitation services</u>			Developmental delay, education & training excluded.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	90 days per plan year. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	<u>Preauthorization</u> is required for Select DME. If you don't get <u>preauthorization</u> , there is a penalty of 20% up to a maximum of \$500.
	<u>Hospice services</u>	20% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> *	1 exam per plan year.
	Children's glasses	Not covered	Not covered	None
	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 | • Infertility Treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long-Term Care | • Weight Loss Programs |
| • Dental Care (Dental coverage is available as a separate option) | • Private Duty Nursing | |

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

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|---|---|--------------------|
| • Acupuncture | • Hearing Aids (1 per ear, every 24 months) | • Routine Eye Care |
| • Chiropractic Care (20 visits per plan year) | • Most non-elective services provided outside the United States | |

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 <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,670

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,800

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$3,000
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500