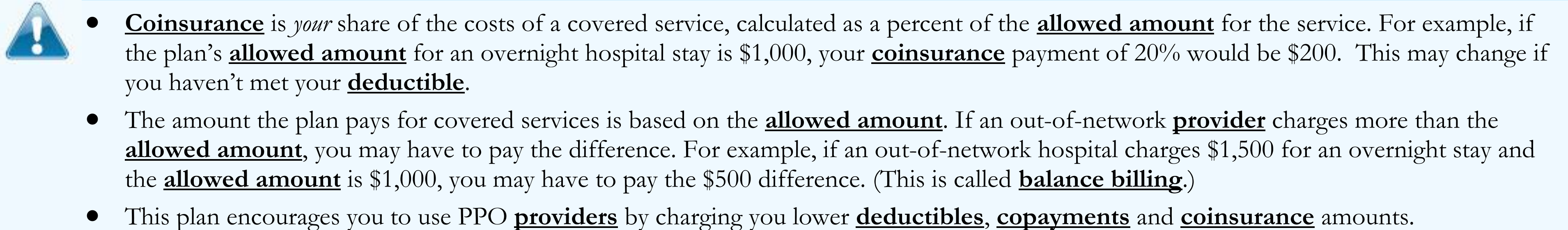
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.healthscopebenefits.com or by calling 1-800-884-0306.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO: **$650** Individual / **$1,950** Family. Non-PPO: **$1,300** Individual/ **$3,900** Family. Out-of-Area: **$650** Individual / **$1,950** Family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over each year on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, **$50** for prescription drug expenses.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: **$3,950** Individual **/ $7,900** Family. Out-of-Network: **$7,900** Individual / **$15,800** Family Out-of-Area: **$3,950** Individual **/ $7,900** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (Plan Year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums (contributions), balance-billed charges, copayments, deductibles, coinsurance for chiropractic services, TMJ services, out-of-pocket expenses where pre-certification is required and not obtained, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2,000,000.	This plan will pay for covered services only up to this limit during each coverage period. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.

Does this plan use a network of providers?	Yes. See www.myCIGNAforhealth.com **or call 1-800-884-0306** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about **excluded services**.



- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan encourages you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	40% coinsurance	See Summary Plan Description (SPD)
	Specialist visit	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Other practitioner office visit	50% coinsurance for chiropractic services; 20% coinsurance for acupuncture services	50% coinsurance for chiropractic services; 20% coinsurance for acupuncture services	50% coinsurance for chiropractic services; 40% coinsurance for acupuncture services	Maximum benefit of $15 per person per visit; Maximum benefit of $500 per person per calendar year
	Routine pap smears, prostate screenings, mammograms, & colonoscopies	20% coinsurance	20% coinsurance	40% coinsurance	Consultation & laboratory charges

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	For Non PPO Providers: 20% coinsurance for radiologists, anesthesiologists, and pathologists when performed at an in-network facility
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$14.50 copay (retail 30-day supply); $29 copay (mail order 90-day supply)	$29.00 copay / prescription (retail)	$29.00 copay / prescription (retail)	See SPD
	Brand Name Contractor drugs	Retail: Drug cost / Member Copay $0 - $45 / 100% $45 - $90 / $45 $90 - $180 / 50% >$180 / $90 Mail order: Drug cost / Member Copay $0 - $90 / 100% $90 - $180 / $90 $180 - $360 / 50% >$360 / $180	Retail: 50% of drug cost with the following limits: Drug cost / Member Copay $0 - $90 / 100% $90 - $180 / $90 $180 - $360 / 50% >$360 / $180	Retail: 50% of drug cost with the following limits: Drug cost / Member Copay $0 - $90 / 100% $90 - $180 / $45 $180 - $360 / 50% >$360 / $180	For Out-of-Area and Non-PPO providers: Claims must be submitted for reimbursement. See SPD for detail.
	Non-Preferred Brand Name Contractor drugs	Same as Brand Name Contractor drugs	Same as Brand Name Contractor drugs	Same as Brand Name Contractor drugs	Same as Brand Name Contractor drugs

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification required.
If you need immediate medical attention (no hospital stay)	Emergency room services	$285 copay, then 20% coinsurance / visit	$285 copay, then 20% coinsurance / visit	$285 copay, then 40% coinsurance / visit	See SPD
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	See SPD
	Urgent care	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification is required.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	40% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification is required.
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification is required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use an Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to one visit per day
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Skilled nursing care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 120 day maximum.
	Durable medical equipment	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
	Hospice service	20% coinsurance	20% coinsurance	40% coinsurance	See SPD
Eye care	Eye exam	Not Covered	Not Covered	Not Covered	N/A
	Glasses	Not Covered	Not Covered	Not Covered	N/A
	Contact Lenses	Not Covered	Not Covered	Not Covered	N/A

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Routine eye care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a contribution, which may be significantly higher than the contributions you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-884-0306. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 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.

Your Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal.** For questions about your rights, this notice, or assistance, you can contact: HealthSCOPE Benefits Customer Service at 1-800-884-0306, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance at 1-800-726-7390 or www.insurance.mo.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,360
- **Patient pays** $2,180

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$650
Copays	$0
Coinsurance	$1340
Limits or exclusions	$190
Total	**$2,180**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $2,400
- **Plan pays** $1,400
- **Patient pays** $1,000

Sample care costs:

Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Total	**$2,400**

Patient pays:

Deductibles	$650
Copays	$0
Coinsurance	$350
Total	**$1,000**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include contributions.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the contribution you pay. Generally, the lower your contribution, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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