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, www.mypromisehealthplan.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/sbc-glossary or call 1-855-366-6660 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 InVio Provider: Individual only $750; Family $2,250 per benefit period. Tier 2 Cigna Provider: Individual only $1,500; Family $4,500 per benefit period. Out-of-Network Provider: Not applicable.	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. The following services by Tier 1 or Tier 2 In-Network Providers Office visits, Preventive care, Prescriptions at Prisma Health Pharmacies, emergency room care, urgent care, outpatient/ inpatient mental health/substance abuse services, initial pregnancy consult, and rehabilitation 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 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?	Yes. $50 per person for prescription drugs. Pharmacy deductible does not apply at Prisma Health Pharmacies.	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?	Tier 1 InVio Provider: Individual $4,000; or Family $8,000 per benefit period. Tier 2 Cigna Provider: Individual $6,250 or Family $12,500 per benefit period. Out-of-Network Provider: Not applicable.	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, 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 Promise Health Plan Provider Directory (https://tinyurl.com/47npv4t3) or call 1-855-366-6660 for a list of network providers	You pay the least if you use a Tier 1 InVio Provider. You pay more if you use a Tier 2 Cigna Provider . 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 tier 1 or 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
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	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	Office Visit Only: $20 copayment/visit (deductible does not apply) Office surgery: 15% coinsurance	Office Visit Only: $40 copayment/visit (deductible does not apply) Office surgery: 40% coinsurance	Not covered	All other services not listed in the office could apply deductible and coinsurance.
	Specialist visit	Office Visit Only: $50 copayment/visit (deductible does not apply) Office surgery: 15% coinsurance	Office Visit Only: $80 copayment/visit (deductible does not apply) Office surgery: 40% coinsurance	Not covered	All other services not listed in the office could apply deductible and coinsurance.
	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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Labs: 15% coinsurance (deductible does not apply) X-ray: 15% coinsurance	40% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	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.caremark.com or call 1-833-267-0413 for member services. Providers call 1-800-364-6331 for the pharmacy help desk.	Generic drugs	Retail 30-day supply: $10 copayment/prescription Retail/Mail Order 31-90 day supply: $20 copayment/prescription (deductible does not apply at Prisma Health pharmacies)	Retail 30-day supply: $20 copayment/prescription after prescription drug deductible; Retail/Mail Order 31-90-day supply: $40 copayment/prescription after prescription drug deductible	Not covered	Prescription drugs are subject to a $50 deductible per person. This deductible does not apply at Prisma Health pharmacies. Copayment applies to a 30-day supply for Retail and Specialty drugs; or 31-90 day supply for a Retail or Mail-Order prescription at a network pharmacy. Copayment does not apply to preventive drugs required by the Affordable Care Act, including contraceptive drugs & devices obtainable from a pharmacy. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. The cost difference does not apply to the deductible or out-of-pocket. Oral and Injectable fertility drugs are limited to $25,000 per lifetime.
	Preferred drugs	Retail 30-day supply: $40 copayment/prescription, Retail/Mail Order 31-90-day supply: $80 copayment (deductible does not apply at Prisma Health pharmacies)	Retail 30-day supply:$60 copayment/prescription after prescription drug deductible; Retail/Mail Order 31-90-day supply: $120 copayment after prescription drug deductible	Not covered	
	Non-preferred drugs	Retail 30-day supply: $55 copayment/prescription; Retail/Mail Order 31-90-day supply: $110 copayment/prescription (deductible does not apply at Prisma Health pharmacies)	Retail 30-day supply: $100 copayment/prescription after prescription drug deductible; Retail/Mail Order 31-90-day supply: $200 copayment/prescription after prescription drug deductible	Not covered	
	Specialty drugs	Preferred/Non-preferred specialty: $125 copayment/prescription (deductible does not apply at Prisma Health pharmacies)	Preferred/Non-preferred: $125 copayment/prescription, after prescription drug deductible	Not covered	$200 maximum member responsibility for each 30-day supply. All prescriptions must be filled by the Specialty pharmacy. Contact PrudentRx at 1-800-578-4403.

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required for surgeries. Failure to obtain pre-certification could result in claim denial.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Not covered	None.
If you need immediate medical attention	Emergency room care	$275 copayment/visit (deductible does not apply)	$275 copayment/visit (deductible does not apply)	$275 copayment/visit (deductible does not apply)	Copayment waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	None.
	Urgent care	$50 copayment/visit (deductible does not apply)	$50 copayment/visit (deductible does not apply)	$50 copayment/visit (deductible does not apply)	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit Only: $20 copayment/visit (deductible does not apply) Other outpatient services: 15% coinsurance (deductible does not apply)	Office Visit Only: $20 copayment/visit (deductible does not apply) Other outpatient services: 15% coinsurance (deductible does not apply)	Not covered	None.
	Inpatient services	15% coinsurance (deductible does not apply)	15% coinsurance (deductible does not apply)	Not covered	Pre-certification is required for inpatient stays, and residential treatment. Failure to obtain pre-certification could result in claim denial.

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and other services described elsewhere in this document. Pre-certification is required for high-risk maternity. Failure to obtain pre-certification could result in claim denial.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	Not covered	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial.
	Rehabilitation services	$20 copayment/visit (deductible does not apply)	40% coinsurance (deductible does not apply)	Not covered	Pre-certification is required for in-patient rehabilitation services. Failure to obtain pre-certification could result in claim denial.
	Habilitation services	0% coinsurance	0% coinsurance	Not covered	
	Skilled nursing care	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial.

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Durable medical equipment	15% coinsurance	40% coinsurance	Not covered	Limited to 1 durable medical equipment item for same/similar purposes. Excludes repairs for misuse/abuse.
	Hospice services	15% coinsurance	40% coinsurance	Not covered	None.
If your child needs dental or eye care	Children's eye exam	Not covered	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 & Child)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- 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 (15 visits per benefit period)
- Bariatric surgery (limited to Tier 1 services only)
- Chiropractic care
- Hearing aids (1 per ear per benefit period)
- Infertility treatment (for more information & exceptions refer to the medical plan document)
- Private-duty nursing (Covered with home health services)

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

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 on how 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 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 1-855-366-6660.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-366-6660.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-366-6660.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-366-6660 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-366-6660.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-366-6660.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-366-6660.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-366-6660.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 (Tier 1 InVio Provider)**	**$750**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**15%**
■ **Other coinsurance**	**15%**

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	$800
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,620**

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

■ **The plan's overall (Tier 1 InVio Provider)**	**$750**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**15%**
■ **Other coinsurance**	**15%**

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	$800
Copayments	$2,000
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,840**

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

■ **The plan's overall (Tier 1 InVio Provider)**	**$750**
■ **Specialist copayment**	**$50**
■ **Hospital (facility) coinsurance**	**15%**
■ **Other coinsurance**	**15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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, www.mypromisehealthplan.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/sbc-glossary or call 1-855-366-6660 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 InVio Provider: Individual only: $2,000; Individual within a family $3,400 or Family $4,000 per benefit period. Tier 2 Cigna Provider: Individual only $3,500; Individual within a family $3,500 or Family $7,000 per benefit period. Out-of-Network Provider: Individual only $4,000; Individual within a family $4,000 or Family $8,000 per benefit period.	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. The following services by Tier 1 or Tier 2 In-Network Providers: Preventive care	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?	Tier 1 InVio Provider: Individual only $4,000/ Individual within a family $4,000; Family $8,000 per benefit period. Tier 2 Cigna Provider: Individual only $6,250; Individual within a family $6,250 or Family $12,500 per benefit period. Out-of-Network Provider: Unlimited/individual or Unlimited/family per benefit period.	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, 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 Promise Health Plan Provider Directory (https://tinyurl.com/47npv4t3) or call 1-855-366-6660 for a list of network providers	You pay the least if you use a Tier 1 InVio Provider: You pay more if you use a Tier 2 Cigna Provider . 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 Tier 1 InVio Provider: or Tier 2 Cigna 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
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	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	15% coinsurance	40% coinsurance	60% coinsurance	None.
	Specialist visit	15% coinsurance	40% coinsurance	60% coinsurance	None.
	Preventive care/screening/immunization	No charge	No charge	60% 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)	15% coinsurance	40% coinsurance	60% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	60% coinsurance	Pre-certification is required. Failure to obtain pre-certification could result in claim denial

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider: (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	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.caremark.com or call 1-833-267-0413 for member services. Providers call 1-800-364-6331 for the pharmacy help desk.	Generic drugs	Retail 30-day supply: $10 copayment/ prescription after deductible Retail/Mail Order 30-90-day supply:$20 copayment/prescription after deductible	Retail 30-day supply: $20 copayment/ prescription after deductible Retail/Mail Order 30-90-day supply: $40 copayment/prescription after deductible	Not covered	Copayment applies to a 30-day supply for Retail and Specialty drugs or 30-90 day supply for a Retail or Mail-Order prescription or at a network pharmacy. Copayment does not apply to preventive drugs required by the Affordable Care Act, including contraceptive drugs and devices obtainable from a pharmacy. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. The cost difference does not apply to the deductible or out-of-pocket. Oral and injectable fertility drugs are limited to $25,000 per lifetime.
	Preferred drugs	Retail 30-day supply: $40 copayment/ prescription after deductible Retail/Mail Order 30-90-day supply: $80 copayment/prescription after deductible	Retail 30-day supply: $60 copayment/ prescription after deductible Retail/Mail Order 30-90-day supply: $120 copayment/prescription after deductible	Not covered	
	Non-preferred drugs	Retail 30-day supply: $55 copayment after deductible Retail/Mail order: $110 copayment after deductible	Retail 30-day supply: $100 copayment after deductible Retail/Mail order: $200 copayment after deductible	Not covered	
	Specialty drugs	20% coinsurance	20% coinsurance	Not covered	$200 maximum member responsibility for each 30-day supply. All prescriptions must be filled by the Specialty pharmacy. Contact PrudentRx at 1-800-578-4403.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider: (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	60% coinsurance	Pre-certification is required for some surgeries. Failure to obtain pre-certification could result in claim denial
	Physician/surgeon fees	15% coinsurance	40% coinsurance	60% coinsurance	None.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	15% coinsurance	None.
	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	None.
	Urgent care	15% coinsurance	40% coinsurance	60% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	60% coinsurance	Pre-certification is required. Failure to obtain pre-certification could result in claim denial
	Physician/surgeon fees	15% coinsurance	40% coinsurance	60% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & Other outpatient services: 15% coinsurance	Office & Other outpatient services: 15% coinsurance	Office & Other outpatient services: 60% coinsurance	None.
	Inpatient services	15% coinsurance	15% coinsurance	60% coinsurance	Pre-certification is required for inpatient stays and residential treatment. Failure to obtain pre-certification could result in claim denial

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider: (You will pay the most)	
If you are pregnant	Office visits	No charge	40% coinsurance	60% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in this document. Pre-certification is required for high- risk maternity. Failure to obtain pre-certification could result in claim denial.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial
	Rehabilitation services	15% coinsurance	40% coinsurance	60% coinsurance	Pre-certification is required for in-patient rehabilitation services. Failure to obtain pre-certification could result in claim denial.
	Habilitation services	0% coinsurance	40% coinsurance	60% coinsurance	
	Skilled nursing care	15% coinsurance	40% coinsurance	Not covered	Pre-certification is required. Failure to obtain pre-certification could result in claim denial
	Durable medical equipment	15% coinsurance	40% coinsurance	60% coinsurance	Limited to 1 durable medical equipment item for same/similar purposes. Excludes repairs for misuse/abuse.
	Hospice services	15% coinsurance	40% coinsurance	Not covered	None.

* For more information about limitations and exceptions, see the plan or policy document at www.mypromisehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 InVio Provider (You will pay the least)	Tier 2 Cigna Provider (You will pay more)	Out-of-Network Provider: (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	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 & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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 (15 visits per benefit period)
- Bariatric surgery (limited to Tier 1 services only)
- Chiropractic care
- Hearing aids (1 per ear per benefit period)
- Infertility treatment (for more information & exceptions refer to the medical plan document)
- Private-duty nursing (Covered with home health services)

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 on how 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 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 1-855-366-6660.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-366-6660.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-366-6660.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-366-6660 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-366-6660.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-366-6660.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-366-6660.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-366-6660.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 (Tier 1 InVio Provider:)** **$2,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$2,000
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

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

- **The plan's overall (Tier 1 InVio Provider:)** **$2,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$2,000
Copayments	$90
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,710**

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

- **The plan's overall (Tier 1 InVio Provider:)** **$2,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

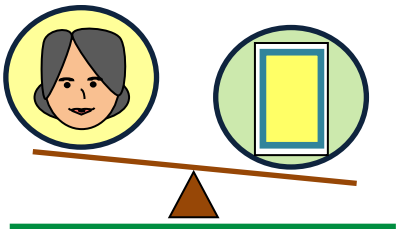
Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance



(See page 6 for a detailed example.)

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

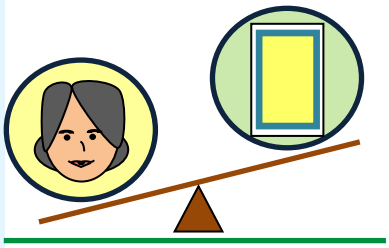
Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

OMB control number: 0938-1146/Expiration date: 05/31/2026

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

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.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

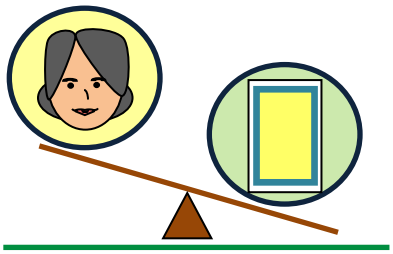
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



Jane pays 0% | Her plan pays 100%

(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

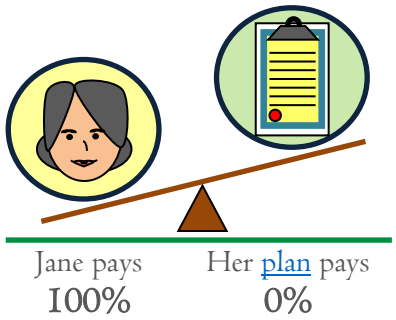
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

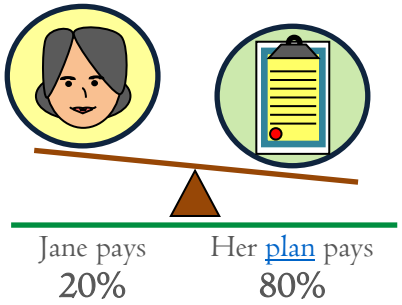
December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

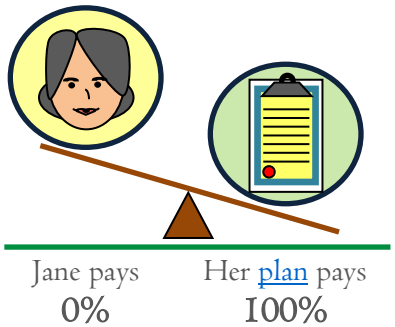
Office visit costs: $125
Jane pays: $125
Her plan pays: $0



Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.