



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-435-5694 or visit us at www.pbaclaims.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 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	If enrolled in Single coverage: \$4,500 If enrolled in Family coverage: \$9,000 * * The PPO <u>deductible</u> for any individual family member will not exceed \$8,150.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the plan begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. PPO preventive care is 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>?	If enrolled in Single coverage: PPO: \$6,350 / Non-PPO: \$13,000 If enrolled in Family coverage: PPO: \$12,700 * / Non-PPO: \$26,000 * The PPO <u>out-of-pocket limit</u> for any individual family member will not exceed \$8,150.	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 plan, the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	The <u>out-of-pocket limit</u> does not include non-compliance penalties, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. For a list of network providers visit www.myCigna.com or call (800) 435-5694	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a referral.

City of Lake Forest: Employee Basic Health Plan with HSA



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
		PPO Provider (You'll pay the least)	Non-PPO Provider (You'll pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Chiropractic services: limited to 20 visits per 6-month period.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care/screening/</u> immunization	No charge (no <u>deductible</u>)	50% <u>coinsurance</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at 800.759.3203 serve-you-rx.com	Generic drugs	20% <u>coinsurance</u>		Cost sharing does not apply to certain preventive services.
	Formulary brand drugs	20% <u>coinsurance</u>		Limits: 34-day supply (retail); 102-day supply (mail order)
	Non-Formulary brand drugs	20% <u>coinsurance</u>		Specialty drug limit: 30-day supply; however, split fill program may limit first month's supply (1 st fill limited to 15-day supply with subsequent 15-day supply refill; 30-day supply max. thereafter).
	<u>Specialty drugs</u>	20% <u>coinsurance</u>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. The non-compliance penalty is \$500.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You'll pay the least)	Non-PPO Provider (You'll pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. The non-compliance penalty is \$500.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. The non-compliance penalty is \$500.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Facility: 120 days/year. <u>Preauthorization</u> is required; non-compliance penalty is \$500.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

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|--------------------|--|------------------------|
| • Acupuncture | • Hearing aids | • Routine eye care |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

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| • Bariatric surgery | • Infertility treatment (limited to 4 completed oocyte retrievals while covered under the plan) | • Private-duty nursing |
| • Chiropractic care | | |

City of Lake Forest: Employee Basic Health Plan with HSA

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694. You may also contact the 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al **1-800-435-5694**.

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>	\$4,500
■ <u>Specialist coinsurance</u>	20%
■ 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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,500
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$1,000
What isn't covered	
Limits or exclusions	\$210
The total Peg would pay is	\$5,730

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>	\$4,500
■ <u>Specialist coinsurance</u>	20%
■ 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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$540
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$5,080

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$4,500
■ <u>Specialist coinsurance</u>	20%
■ 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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Please note: These coverage examples are based on self-only coverage. The "Having a Baby" example includes charges for the baby. These charges are not considered under the mother, but would be considered under the baby.