**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 1-800-348-7468 x3368 or go to https://www.mennonitemission.net/Serve/Mennonite%20Voluntary%20Service/participant-information. 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 1-800-348-7468 x3368 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 for network providers<br>$1,400 for out-of-network providers | See the Common Medical Events chart below for your costs for services this plan covers.<br>Generally you must pay all of the costs from out-of-network providers up to the out-of-network deductible amount each plan year (Aug. 1 through July 31) before this plan begins to pay for out-of-network services. |
| **Are there services covered before you meet your deductible?** | There is no deductible requirement for network providers.<br>Yes, for out-of-network providers. Emergency room care, emergency medical transportation, eye exams, glasses, dental exams, and required dental services are covered before you meet your out-of-network deductible. | This plan covers some out-of-network items and services even if you haven't yet met the out-of-network deductible amount. |
| **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?** | $0 for network providers<br>$4,200 for out-of-network providers | The out-of-pocket limit is the most you could pay in a plan year for covered services. |
| **What is not included in the out-of-pocket limit?** | 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 www.cigna.com or call 1-800-348-7468 x3368 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge | 40% coinsurance | None |
| | Specialist visit | No charge | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.<br>Routine physical exams and routine diagnostic screenings not covered during first year of service. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | No charge | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available by calling 1-800-348-7468 x2460 | Tier 1 Generic drugs | No charge (retail and mail order) | Not covered | Covers specialty drugs up to a 30-day supply. Covers all other drugs up to a 34-day or 100-unit supply for retail purchase; 90-day supply for mail order purchase.<br>Preauthorization required for compound drugs costing $300 or more, any drug costing $5,000 or more, and all specialty drugs. No benefits without preauthorization or if specialty drugs are not purchased as directed by CVS Caremark from a Caremark specialty pharmacy.<br>No benefits if membership card is not used. |
| | Tier 2 Preferred brand drugs | No charge (retail and mail order) | Not covered | |
| | Tier 3 Non-preferred brand drugs | No charge (retail and mail order) | Not covered | |
| | Tier 4 Specialty drugs | No charge | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 40% coinsurance | Preauthorization is required prior to any spinal procedure that punctures the skin or benefits could be reduced by $250. |
| | Physician/surgeon fees | No charge | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | No charge | No charge. Deductible does not apply. | None |
| | Emergency medical transportation | No charge | No charge. Deductible does not apply. | |
| | Urgent care | No charge | 40% coinsurance | |

| 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) | No charge | 40% coinsurance | Preauthorization is required prior to an inpatient admission or benefits could be reduced by $250. |
| | Physician/surgeon fees | No charge | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | 40% coinsurance | None |
| | Inpatient services | No charge | 40% coinsurance | Preauthorization is required prior to an inpatient admission or benefits could be reduced by $250. |
| **If you are pregnant** | Office visits | Not covered | Not covered | Excluded services |
| | Childbirth/delivery professional services | Not covered | Not covered | |
| | Childbirth/delivery facility services | Not covered | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 40% coinsurance | None |
| | Rehabilitation services | No charge | 40% coinsurance | Physical medicine limited to 20 visits/year; speech therapy limited to 20 visits/year; occupational therapy limited to 20 visits/year. |
| | Habilitation services | No charge | 40% coinsurance | |
| | Skilled nursing care | No charge | 40% coinsurance | Limited to 100 days/year. Preauthorization is required prior to an inpatient admission or benefits could be reduced by $250. |
| | Durable medical equipment | No charge | 40% coinsurance | Excludes vehicle modifications, home modifications, and exercise equipment. |
| | Hospice services | No charge | 40% coinsurance | Preauthorization is required prior to an inpatient admission or benefits could be reduced by $250. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge. Deductible does not apply. | Not covered during first year of service. |
| | Children's glasses | No charge | No charge. Deductible does not apply. | |
| | Children's dental check-up | No charge | No charge. Deductible does not apply. | |

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except to correct a congenital defect, a condition resulting from an accidental injury, or a functional impairment resulting from a covered illness or injury)
- Hearing aids
- Long-term care
- Maternity services – delivery and inpatient services
- Maternity services – prenatal and postnatal care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except when related to treatment of diabetes)
- Weight loss programs

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

- Chiropractic care, up to 20 visits/year
- Dental care – Adult (routine dental exam and required dental services), up to $300/year per adult and $500/year per family (adults only) for dental care and routine eye care, combined. Not covered during first year of service.
- Infertility treatment (diagnosis and treatment of underlying medical condition)
- Private-duty nursing
- Routine eye care – Adult (eye exam and prescription lenses), up to $300/year per adult and $500/year per family (adults only) for dental care and routine eye care, combined. Not covered during first year of service.

**Your Rights to Continue Coverage:** For more information on your rights to continue coverage, contact the plan at 1-574-294-7523. 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:** Assistance is available 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: Everence Insurance Company at 1-800-348-7468 x3368 or your plan representative at 1-574-294-7523.

**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 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.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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** |
|---|---|

**In this example, Peg would pay:**
(this condition is not covered so patient pays 100%)

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,800 |
| **The total Peg would pay is** | **$12,800** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$20** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist | $0 |
| Hospital (facility) | $0 |
| Other | $0 |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

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