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.naa-lp.com or by calling 1-800-411-3650. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.naa-lp.com or call 1-800-411-3650 to request a copy.

Cost to the Employee	Single: $125/month Family: $750/month	Employees are eligible after 90 days of Full-Time Employment.
What is the overall deductible?	PPO $120 individual/$370 family; Non-PPO $120 individual/ $370 family.	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. Pre-admission testing visits 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 individual/ $150 family for dental coverage. Dental deductible does not apply to preventive services. There are no other specific deductibles.	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?	For PPO providers $120 individual / $370 family; Non-PPO providers $240 individual / $740 family	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?	Any deductibles, penalties, non-covered expenses, and any expenses originally covered at 100%	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.myCigna.com or call 866-494-2111 for a list of PPO 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 permission from this plan.

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 will pay the least)	Non-PPO 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	10% coinsurance	20% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	10% coinsurance	20% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MagellenRX.com	Generic drugs	Retail $6 copay Mail $18 copay	Not covered	Covers up to a 100-day supply retail or mail order. Maintenance drugs should be purchased through the Mail Service Program. Specialty drugs are limited to 30-day supply.
	Preferred brand drugs	Retail $24 copay Mail $72 copay	Not covered	
	Non-preferred brand drugs	Retail $24 copay Mail $72 copay	Not covered	
	Specialty drugs	Retail $24 copay Mail $72 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	20% coinsurance	
	Urgent care	10% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Limited to semi-private room rate. Facility with private rooms only will have a reduced benefit of 20% coinsurance for PPO Providers. Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	Limited to semi-private room rate. Facility with private rooms only will have a reduced benefit of 20% coinsurance for PPO Providers. Preauthorization is required.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Preauthorization is required.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	160 visits/year. Preauthorization is required.
	Rehabilitation services	10% coinsurance	20% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required for speech therapy.
	Habilitation services	10% coinsurance	20% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	120 visits/calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	20% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Except as required by ACA as a preventive care service.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No cost sharing	No cost sharing	If optional dental is elected

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	• Infertility Treatment	• Routine eye care (Adult)
• Bariatric Surgery	• Long Term Care	• Routine Foot Care
• Cosmetic Surgery	• 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.)	
• Chiropractic Care	• Hearing Aids ($1,000 lifetime max)
• Dental Care (optional)	• Private Duty Nursing

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: 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 . 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: Hall Communications, Inc. c/o North America Administrators, L.P. at 1-800-411-3650 or P O Box 25207, Nashville, TN 37202. 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.

Grandfathered Plan:
This plan is grandfathered under the Affordable Care Act. Please refer to the SPD for more information.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-411-3650.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-411-3650.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-411-3650.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-411-3650.

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	$120
Specialist copayment	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$120
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$300

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

The plan's overall deductible	$120
Specialist copayment	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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*	$120
Copayments	$60
Coinsurance	$120
What isn't covered	
Limits or exclusions	$1200
The total Joe would pay is	$1500

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

The plan's overall deductible	$120
Specialist copayment	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$120
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$240

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