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, go online at www.cigna.com/sp. 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 1-888-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** per person/ **$3,000** Family In-Network **$3,000** per person/**$6,000** Family Out-of-Network. Does not apply to In-Network preventative care.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations 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-carebenefits/.
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?	For in-network providers **$5,000**/individual or **$10,000**/ family For out-of-network providers **$10,000**/individual or **$20,000**/ 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?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and healthcare 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. For a list of In-Network providers, see **www.corehealthbenefits.com or call 1-888-741-2673.**	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 **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
		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	$20 Copay	Deductible + 50% coinsurance	None
	Specialist visit	$50 Copay	Deductible + 50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% 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)	In Physician's office: No charge/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 50% coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Physician's Office: $50 Copay/ Independent Diagnostic Center: Deductible + 20% Coinsurance	Deductible + 50% coinsurance	Prior authorization may be required. Tests performed in hospitals may have higher cost share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	$10 copay/prescription (retail) **OR** $20/copay prescription (mail order)	Not covered	Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs	$30 copay /prescription (retail) **OR $**60 copay/ prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$50 co-pay (retail) **OR** $100 co-pay (mail order)	Not Covered	
	Specialty drugs	$150	Not Covered	See above categories.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	$250 Penalty for no precertification.
	Physician/surgeon fees			None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	None

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)	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance	None
	Urgent care	$55 Copay	Deductible + $55 Copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	$250 Penalty for no precertification.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	$250 Penalty for no precertification.
	Inpatient services			
If you are pregnant	Office visits Primary/ Specialist (Initial visit only)	$20 copay/ $50 Copay	50% coinsurance after deductible	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). $250 penalty for no precertification.
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	$250 penalty for no precertification. Coverage is limited to 120 per calendar year. One visit is considered 4 hours of home health aide services.
	Rehabilitation services	$50 Copay	50% coinsurance after deductible	25 days per calendar year maximum. Preauthorization required.
	Habilitation services			
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all DME in excess of $500, penalty for noncompliance
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. $250 penalty for no precertification.

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 your child (under 19) needs dental or eye care	Children's eye exam	No Charge	Not Covered	One exam per calendar year.
	Children's glasses	No Charge See limitations & exceptions	Not Covered	One pair per calendar year. $150 allowance towards frames OR contact lenses. Eyeglass Lenses no cost. Anything over the allowance will NOT go toward your Out of Pocket max.
	Children's dental check-up	No Charge	Not Covered	Coverage includes preventative cleanings once per 6 months and 1 set of bitewing x-rays.

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
- Dental (Adult)
- Hearing aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- 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.)

- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-741-2673. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: [insert applicable contact information from instructions].

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-741-2673.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-741-2673.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-741-2673.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-741-2673.

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	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$50
Coinsurance	$2250
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3800**

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

The plan's overall deductible	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$500
Coinsurance	$1080
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3080**

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

The plan's overall deductible	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$70
Coinsurance	$186
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2386**

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