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?	**$1,950** per person/ **$3,900** Family In-Network **$5,000** per person/**$10,000** Family Out-of-Network Combined medical/behavioral and pharmacy deductible. Deductible per individual applies when the employee is the only individual covered under the plan.	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 **$6,350**/individual or **$12,700**/ family (no more than **$6,850** per individual in the family); For out-of-network providers **$12,700**/individual or **$25,400**/ family (no more than **$25,400** per individual in the 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.

For more information about limitations and exceptions, see the plan or policy document at www.corehealthbenefits.com. OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 6, 2016.

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	10% or 20% coinsurance	40% coinsurance	None
	Specialist visit	10% or 20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge/visit** No charge/screening No charge/ immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/screening 40% coinsurance/ immunizations	None 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% or 20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% or 20% coinsurance	40% coinsurance	50% penalty for no precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	$12 copay/prescription (retail) **OR** $24/copay prescription (mail order)	50% coinsurance	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. ***Deductible applies before pharmacy copays begin.**
	Preferred brand drugs	$50 copay /prescription (retail) **OR $**100 copay/ prescription (mail order)	50% coinsurance	
	Non-preferred brand drugs	$70 co-pay (retail) **OR** $140 co-pay (mail order)	50% coinsurance	
	Specialty drugs	See above	See above	See above categories.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% or 20% coinsurance	40% coinsurance	50% Penalty for no precertification.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	10% or 20% coinsurance	20% coinsurance	None
	Emergency medical transportation	10% or 20% coinsurance	20% coinsurance	None
	Urgent care	10% or 20% coinsurance	20% coinsurance	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% or 20% coinsurance	40% coinsurance	50% penalty for no preauthorization.
	Physician/surgeon fees	10% or 20% coinsurance	40% coinsurance	50% penalty for no preauthorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% or 20% coinsurance	40% coinsurance	50% penalty for no preauthorization.
	Inpatient services			
If you are pregnant	Office visits	10% or 20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	10% or 20% coinsurance	40% coinsurance	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). 50% reduced benefits/coinsurance for noncompliance.
	Childbirth/delivery facility services	10% or 20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% or 20% coinsurance	40% coinsurance	50% penalty for no precertification. Coverage is limited to 60 days annual max. Maximums
	Rehabilitation services	10% or 20% coinsurance after deductible	50% coinsurance after deductible	25 days per calendar year maximum. Preauthorization required.
	Habilitation services			
	Skilled nursing care	10% or 20% coinsurance after deductible	50% coinsurance after deductible	30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment	10% or 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all DME in excess of $500, penalty for noncompliance
	Hospice services	10% or 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Vision screening ONLY under Medical Plan. $100 calendar year maximum.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	Oral health risk assessment ONLY under Medical

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)	
				Plan; see Dental Plan.

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	$1950
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$1950
Copayments	$108
Coinsurance	$1074
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3132**

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

The plan's overall deductible	$1950
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$1950
Copayments	$500
Coinsurance	$495
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2945**

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

The plan's overall deductible	$1950
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1950
Copayments	$36
Coinsurance	$51
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2037**

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