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.mycoresource.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 1-877-267-2323 extension 61565 to request a copy. Questions: Call 1-800-624-7130 or visit us at www.mycoresource.com for more information, including a copy of your plan's plan document and summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $0/individual or $0/family. For nonpreferred providers: $200/individual or $400/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. There is no deductible for preferred providers.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers: $500/individual or $1,500/family. For nonpreferred providers: $750/individual or $2,000/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?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	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 1-800-624-7130 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 **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
		Preferred Provider (You will pay the least)	Nonpreferred 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	$12 copay/visit	20% coinsurance	None.
	Specialist visit	$12 copay/visit	20% coinsurance	None.
	Preventive care/screening/ immunization	No charge	20% coinsurance	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	Diagnostic test (x-ray, blood work)	15% coinsurance	25% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	20% coinsurance/retail; $10 copay/mail order		Member pays for prescription at retail pharmacy and submits to CoreSource for reimbursement. Retail prescription drugs are subject to nonpreferred provider deductible and out-of-pocket limit.
	Preferred brand drugs	20% coinsurance/retail; $10 copay/mail order		
	Non-preferred brand drugs	20% coinsurance/retail; $10 copay/mail order		
	Specialty drugs	20% coinsurance/retail		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	None.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	None.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance (deductible does not apply)	Nonpreferred provider non-emergency use of the emergency room services have 25% coinsurance after deductible.
	Emergency medical transportation	15% coinsurance	15% coinsurance (deductible does not apply)	None.
	Urgent care	15% coinsurance	25% coinsurance	None.

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
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Preauthorization required for inpatient. Failure to obtain preauthorization may result in facility charges been reduced by $250. No charge for the first $100,000 per confinement. After that, 15% coinsurance for preferred providers and 25% coinsurance after deductible for nonpreferred providers.
	Physician/surgeon fees	15% coinsurance	25% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$12 copay/visit	20% coinsurance	None.
	Inpatient services	No charge	No charge	Preauthorization required for inpatient. Failure to obtain preauthorization may result in facility charges been reduced by $250. No charge for the first $100,000 per confinement. After that, 15% coinsurance for preferred providers and 25% coinsurance after deductible for nonpreferred providers.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound.)
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	None.
	Rehabilitation services	15% coinsurance	25% coinsurance	None.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.

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
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
	Skilled nursing care	15% coinsurance	25% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in facility charges been reduced by $250.
	Durable medical equipment	15% coinsurance	25% coinsurance	None.
	Hospice services	15% coinsurance	25% coinsurance	Preauthorization required for inpatient. Failure to obtain preauthorization may result in facility charges been reduced by $250.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Eye exams are not covered.
	Children's glasses	Not covered	Not covered	Glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered.

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.)

- Cosmetic surgery
- Dental care
- Hearing aids (limitations apply)
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.mycoresource.com
- 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.)

- Acupuncture (limitations apply)
- Bariatric surgery
- 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. 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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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 1-800-624-7130.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-7130.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-624-7130.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-7130.

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	$12
Hospital (facility)	0%
Other	15%

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	$0
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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	$12
Hospital (facility)	0%
Other	15%

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	$72
Coinsurance	$428
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$555**

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

The plan's overall deductible	$0
Specialist	$12
Hospital (facility)	15%
Other	15%

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	$36
Coinsurance	$245
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$281**

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