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 **1-866-364-3544** or visit us at 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 www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$2,500** person / **$5,000** family; for out-of-network providers **$5,000** person / **$10,000** 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, chiropractic benefits, some copayments, charges in excess of specified benefit maximums, 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.mycigna.com or call **866-364-3544** for a list of In-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 don't need a referral to see a specialist.	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
		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 copay / visit	40% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$25 copay / visit	50% coinsurance	For other services received during the office visit, additional member cost-share may apply.
	Other practitioner office visit.	Chiropractic: 50% coinsurance Acupuncture: $25 copay / visit	50% coinsurance for chiropractic and 40% coinsurance for acupuncture	Coverage is limited to 12 chiropractic visits per calendar year. Additional member cost-share applies for x-ray services received during the office visit. Chiro services not subject to calendar year medical deductible.
	Preventive care/screening/ immunization	No charge	Not Covered	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Maximum benefit of $350 per day.
	Imaging (CT/PET scans, MRIs)	10% coinsurance At Outpatient Hospital: $100 copay / visit + 10% coinsurance	40% coinsurance	Maximum benefit of $350 per day.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call **866-644-7527.**	Tier 1 Drugs	$5 copay / prescription (retail) $10 copay / prescription (mail order)	Not Covered	Tier 1 Drugs are not subject to calendar year medical or pharmacy deductible. Retail: Covers up to a 30-day supply. Mail Order: Covers up to a 90-day supply, except Specialty Drugs. Select formulary and non-formulary drugs require prior authorization.
	Tier 2 Drugs	$20 copay / prescription (retail) $40 copay / prescription (mail order)	Not Covered	
	Tier 3 Drugs	$40 copay / prescription (retail) $80 copay / prescription (mail order)	Not Covered	
	Tier 4 Drugs	30% coinsurance up to $250 / prescription (retail/specialty); 30% coinsurance up to $500	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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)	
		/ prescription (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Maximum benefit of $350 per day.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	ER Facility Fee: $100 copay / visit + 10% coinsurance ER Physician Fee: 10% coinsurance	ER Facility Fee: $100 copay / visit + 40% coinsurance ER Physician Fee: 40% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance		None
	Urgent care	$10 copay / visit	$25 copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Maximum benefit of $2,000 per day. Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay / visit (Routine office visit) 10% coinsurance (Non-routine outpatient services)	40% coinsurance	None
	Inpatient services	10% coinsurance	40% coinsurance	Maximum benefit of $2,000 per day. Preauthorization is required.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Prenatal: No charge for initial visit only at participating providers. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Maximum benefit of $2,000 per day. Preauthorization is required.
If you need help recovering or have	Home health care	10% coinsurance	Not Covered	Coverage limited to 100 visits per calendar year. Preauthorization is required.
	Rehabilitation services	10% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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)	
other special health needs	Habilitation services	10% coinsurance	40% coinsurance	Coverage for physical, occupational and respiratory therapy. Outpatient Hospital: Max benefit of $350 per day.
	Skilled nursing care	10% coinsurance	10% coinsurance	Coverage limited to 100 days per calendar year. Preauthorization is required.
	Durable medical equipment	50% coinsurance	Not Covered	Preauthorization is required.
	Hospice services	No Charge	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Coverage up to $30 max allowance	Limit of one comprehensive eye exam per calendar year.
	Children's glasses	No Charge	Coverage up to max allowance of: Single vision $25 Lined bifocal $35 Lined trifocal $45 Lenticular $45	Limited to one pair of eyeglasses (frames and lenses) or one pair of contact lenses per calendar year.
	Children's dental check-up	No Charge	20% coinsurance	Pediatric dental benefits are for members through the end of the month in which the member turns 19. Limit of 2 visits in a 12-month period.

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 (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care, except for diabetes patients
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Dental Care (Child)
- Routine Eye Care (Child)

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 CoreSource at 1-866-364-3544. Or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-EBSA (3272) through EBSA's website at 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-364-3544.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-364-3544.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-364-3544

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-364-3544.

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

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com

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 copayment** **$25**
- **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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,340**

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 copayment** **$25**
- **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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$550
Coinsurance	$190
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$800**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$340**

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