This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at myhealth.healthsmart.com or by calling 1-844-258-2759.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$450 individual/$900 family In-Network $900 individual/$1,800 family Out-of-Network	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $3,450 per covered person In-Network $6,900 per covered person Out-of-Network	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billed charges, healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Cigna. Call 1-844-258-2759 or visit mycigna.com	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In-Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Deductible / 40% coinsurance	In-network office visit copay applies to all services performed in the physician's office.
	Specialist visit	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Other practitioner office visit	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Preventive care/screening/immunization	No charge	No charge	Covered services based on recommended care/screenings.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available from National Pharmaceutical Services at 1-800-546-5677.	Generic drugs	$5 copay retail per prescription		Retail – up to a 30 day supply – 1 copay per prescription Retail – up to a 90 day supply - 2 copays per prescription Over the counter Claritin and Prilosec (with prescription from physician) – no charge
	Preferred brand drugs	$30 copay retail per prescription		
	Non-preferred brand drugs	$50 copay retail per prescription		
	Specialty drugs	20% of prescription cost up to $250 maximum per prescription		Specialty drugs may require pre-authorization, call 1-800-546-5677.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	Deductible / 20% coinsurance	Deductible / 20% coinsurance	----------none----------
	Emergency medical transportation	Deductible / 20% coinsurance	Deductible / 20% coinsurance	----------none----------
	Urgent care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precert required, call HealthSmart at 1-844-258-2759.
	Physician/surgeon fee			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible / 20% coinsurance	In-Network Deductible / 20% coinsurance	Coverage is combined with substance use disorder and limited to 50 visits per calendar year.
	Mental/Behavioral health inpatient services	Deductible / 20% coinsurance	In-Network Deductible / 20% coinsurance	Precert required, call HealthSmart at 1-844-258-2759.
	Substance use disorder outpatient services	Deductible / 20% coinsurance	In-Network Deductible / 20% coinsurance	Coverage is combined with mental/behavioral health services and limited to 50 visits per calendar year.
	Substance use disorder inpatient services	Deductible/ 20% coinsurance	In-Network Deductible / 20% coinsurance	Precert required, call HealthSmart at 1-844-258-2759.
If you are pregnant	Prenatal and postnatal care	No charge	Deductible / 40% coinsurance	----------none----------
	Delivery and all inpatient services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	Precert required, call HealthSmart at 1-844-258-2759.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Rehabilitation services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Habilitation services	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Skilled nursing care	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Durable medical equipment	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
	Hospice service	Deductible / 20% coinsurance	Deductible / 40% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (must meet medical necessity guidelines)
- Chiropractic care
- Hearing aids ($1,400 per ear once every three years)
- Infertility treatment ($15,000 maximum lifetime benefit)
- Private-duty nursing
- Routine foot care (due to metabolic disorder only)
- Weight loss programs

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-844-258-2759. 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

Your Grievance and Appeals Rights: For group health coverage subject to ERISA: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Claims Administrator at 1-844-258-2759.
If there are any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-844-258-2759. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-258-2759. Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-258-2759. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-258-2759.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,990
- Patient pays $1,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$450
Copays	$10
Coinsurance	$940
Limits or exclusions	$150
Total	$1,550

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,280
- Patient pays $1,120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$450
Copays	$350
Coinsurance	$240
Limits or exclusions	$80
Total	$1,120

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.