Subject to plan allowable. **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 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.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For **Network providers** $0/individual or $0/family; For **Non-network providers** N/A	Generally, you must pay all 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. **Preventive 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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For **Network providers** $7,350/individual or $14,700/family; For **Non-network providers** $7,350/individual or $14,700/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, balanced-billing** charges, 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 for a list of participating 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.

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Specialist visit	$50 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Preventive care/screening/ immunization	0% coinsurance	Not covered	Not covered if provided at a hospital. 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. Limited to 1 visit per year. Subject to plan allowable.
If you have a test	Diagnostic test (X-Ray & Lab)	Independent Lab and X-Ray: $50 copay/visit	Not covered	Independent lab, does not include services provided in physician's office or hospital. Limited to 3 visits per year.
	Imaging (CT/PET scans, MRIs)	$350 copay (Subject to Maximum Plan Allowable)	Not covered	Not covered if services are provided at a hospital. Limited to 1 per plan year. Preauthorization is required.
If you need drugs to treat your illness or condition	Generic drugs	$10 copay/prescription for retail; $30 copay/prescription for mail order	Not covered	Only covers generic retail drugs including COVID-19 generics. No specialty drugs or brand drugs covered (except for base contraceptive benefit). Limited to a 30-day supply (retail); 31-90 day supply (mail order prescription). Subject to formulary.
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 1 visit per plan year. Preauthorization is required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 1 visit per plan year.
	Emergency medical transportation	$250 copay (Subject to Maximum Plan Allowable)	Not covered	By land only. Limited to 1 transport per plan year
	Urgent care	$50 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 2 visits per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 3 days per plan year.
	Physician/surgeon fees	Included in Inpatient Hospitalization copay	Not covered	Limited to visits up to 3 days per plan year.
If you need mental health, behavioral health and substance abuse services	Outpatient services	$25 copay/visit	Not covered	Not covered if provided at a hospital. Limited to 6 visits per plan year.
	Inpatient services	$350 copay (Subject to Maximum Plan Allowable)	Not covered	Limited to 3 days per plan year.
If you are pregnant	Office visits	Not covered	Not covered	Not covered
	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered	Not covered

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

Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	$25 copay	Not covered	Limited to 5 visits per plan year. Preauthorization is required.
	Rehabilitation services	$50 copay	Not covered	Combined limit of 6 visits per plan year with physical, speech, and occupational therapies.
	Habilitation services	$50 copay	Not covered	
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

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 care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- ACA Preventive care only

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: Simplan at 800-680-0892 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 the Minimum Value Standards? **No**
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 [800-680-0892]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800-680-0892]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[800-680-0892]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [800-680-0892]

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[copayment]*	$50
Hospital (facility) *[coinsurance]*	$350
Other *[coinsurance]*	0%

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	**$13,254**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,490
The total Peg would pay is	**$3,790**

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

The plan's overall deductible	$0
Specialist *[copayment]*	$50
Hospital (facility) *[coinsurance]*	$350
Other *[coinsurance]*	0%

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	**$8,017**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,050
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,052
The total Joe would pay is	**$7,102**

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

The plan's overall deductible	$0
Specialist *[copayment]*	$50
Hospital (facility) *[coinsurance]*	$350
Other *[coinsurance]*	0%

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	**$2,520**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$810
The total Mia would pay is	**$2,110**

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