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, https://allthingsvault.com/AmazonDSP. 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.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual / $2,000 family; for out-of-network providers $4,000 individual / $8,000 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. 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?	There are no other specific deductibles.	
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; for out-of-network providers 50% coinsurance	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?	Copayments for certain services, premiums, balance-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 https://www.cigna.com/health-care-providers/ or call 1-800-882-4462 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$25 copay/office visit and 20% coinsurance for other outpatient services; deductible applies	50% coinsurance; deductible applies	None.
	Specialist visit	$45 copay/visit	50% coinsurance; deductible applies	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge.	50% coinsurance; deductible applies	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)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://drexi.com/how	Generic drugs	$5 copay/prescription for retail; $10 copay / prescription for 90 day retail or mail-order	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order or retail prescription).
	Brand drugs	$25 copay/prescription for retail; $50 copay/prescription for 90 day retail or mail order	Not Covered	
	Specialty drugs	50% coinsurance to a maximum of $250 for retail; a maximum of $500 for 90 day retail or mail order	Not Covered	

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

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)	
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you have outpatient surgery	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Emergency room care	$250 copay and 20% coinsurance; deductible applies	$250 copay and 20% coinsurance; deductible applies	50% coinsurance for anesthesia.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance; deductible applies	50% coinsurance; deductible applies	None.
	Urgent care	$45 copay	50% coinsurance; deductible applies	
	Facility fee (e.g., hospital room)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you have a hospital stay	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Outpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	None.
	Office visits	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Home health care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	60 visits/year.
	Habilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.

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)	
	Skilled nursing care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Durable medical equipment	20% coinsurance; deductible applies	50% coinsurance; deductible applies	60 visits/calendar year.
	Hospice services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Children's eye exam	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's glasses	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Coverage limited to one exam/year.
	Children's dental check-up	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Coverage limited to one pair of glasses/year.
				None.

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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Bariatric Surgery
- Hearing Aids

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Weight loss programs

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: Contact your state's Department of Insurance for more information. 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 on how 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].

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

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

*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	**$1,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$595
Copayments	$405
Coinsurance	$2,421
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,421**

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

The plan's overall deductible	**$1,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$730
Copayments	$270
Coinsurance	$974
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,974**

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

The plan's overall deductible	**$1,000**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$250
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

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