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, contact your human resources department or visit www.siscobenefits.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 1-866-444-3272 to request a copy
Questions: Call 1-844-631-6104 or visit us at www.siscobenefits.com for more information, including a copy of your plan's summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0 / individual or $0 / family; For out-of-network providers: $500 / individual or $1,000 / 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. In-network preventive care services and prescription drugs 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 In-network providers: $3,000 / individual or $12,700 / family; For out-of-network providers: Unlimited	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?	Pre-certification penalties, 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 an in-network provider?	Yes. See www.multiplan.com or call 1-844-631-6104 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 in-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
		In-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	$15 copay / visit	60% coinsurance	Applies to visit charge only.
	Specialist visit	$25 copay / visit	60% coinsurance	Applies to visit charge only.
	Preventive care/screening/ immunization	No charge	60% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay / service	60% coinsurance	Services in the emergency room limited to a $1,500 maximum payment per visit for all services combined.
	Imaging (CT/PET scans, MRIs)	$400 copay / service	60% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.siscobenefits.com or by calling 1-844-631-6104.	Generic drugs (Tier 1)	Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription		Deductible does not apply to prescriptions. Covers up to a 30-day supply at a retail pharmacy for one copay, a 31 to 60 day supply for 2 times the listed copay or 61 to 90-day supply for 3 times the listed copay. Up to a 90-day supply may be purchased through mail order for the copay listed. If a name brand drug is purchased when a generic is available, you will be responsible for the name brand copay and the difference in cost between the name brand and generic drug. If your physician indicates that only the name brand may be taken, this limitation will not apply.
	Preferred brand drugs (Tier 2)	Retail: $25 copay / prescription Mail Order: $62.50 copay / prescription		
	Non-preferred brand drugs (Tier 3)	Retail: $75 copay / prescription Mail Order: $187.50 copay / prescription		
	Specialty drugs (Tier 4)	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need immediate medical attention	Emergency room care	$400 copay / visit	$400 copay / visit	Limited to a $1,500 maximum payment per visit for all services combined. Copay applies to the in-network out-of-pocket limit. Non-emergency use of the emergency room is not covered.
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	$50 copay / visit	60% coinsurance	Applies to visit charge only.

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay / visit; Other: Not covered	Not covered	Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	$15 copay / visit	60% coinsurance;	Applies to visit charge only. Certain routine prenatal care if billed separate from global fee is included in the Preventive care benefit.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Office: $25 copay / visit; Other: Not covered	Not covered	Limited to 60 visits per plan year for physical, occupational, and speech therapies combined. Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	Habilitation services	Office: $25 copay / visit; Other: Not covered	Not covered	Limited to 30 visits per plan year for physical, occupational, and speech therapies combined. Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Certain vision screenings for children are included in the preventive care benefit.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Durable Medical Equipment
- Emergency Medical Transportation
- Hearing Aids
- Home Health Care
- Hospice Services
- Infertility Treatment
- Inpatient Hospital Services
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Outpatient Surgery
- Private Duty Nursing
- Routine eye care
- Routine Foot Care
- Skilled Nursing Care
- Specialty Drugs
- Weight Loss Programs

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

- Chiropractic Care (limited to 12 visits per plan year)
- Habilitation Services (limited to 30 office visits per plan year)
- Coverage provided outside the United States. See www.siscobenefits.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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or Ask EBSA at their website (https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa). You may also contact your human resources department for information about continuing your coverage; visit www.siscobenefits.com to find a copy of your plan; or call SISCO at 1-844-631-6104. 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: SISCO at 1-844-631-6104 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or Ask EBSA at their website (https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa).

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 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 1-844-631-6104.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-631-6104.

Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-844-631-6104.

Korean (한국어): 한국어로 도움을 받으려면 1-844-631-6104로 전화하십시오

Tagalog (Filipino): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-631-6104.

Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-844-631-6104.

Arabic (عربى): للحصول على المساعدة في اللغة العربية، والدعوة 1-844-631-6104.

French Creole (franse kreyòl): Pou asistans nan franse kreyòl, rele 1-844-631-6104.

French (français): Pour obtenir de l'aide en français, composez le 1-844-631-6104.

Polish (UWAGA): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-631-6104.

Portugese (português): Para obter assistência em português, ligue para 1-844-631-6104.

Italian (italiana): Per assistenza in lingua italiana, chiamare 1-844-631-6104.

German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-844-631-6104.

Japanese （日本語）：日本語の場合は1-844-631-6104までご連絡ください。

Persian (فارسی): برای کمک در فارسی، 1-844-631-6104 تماس بگیرید.

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 copayment	$25
Hospital (facility) coinsurance	NA
Other coinsurance	NA

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	$0
Copayments	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,100
The total Peg would pay is	**$11,420**

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	NA
Other coinsurance	NA

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	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$25
The total Joe would pay is	**$1,225**

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	NA
Other coinsurance	NA

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,200
The total Mia would pay is	**$1,800**

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