
 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](http://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](http://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 <a href="#">deductible</a> ?	For <a href="#">in-network providers</a> : \$3,000 / individual or \$6,000 / family; For <a href="#">out-of-network providers</a> : Not covered.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> : \$6,350 / individual or \$12,700 / family; For <a href="#">out-of-network providers</a> : Not covered.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Pre-certification</a> penalties, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use an <a href="#">in-network provider</a> ?	Yes. See <a href="http://www.mycigna.com">www.mycigna.com</a> or call 1-844-631-6104 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	40% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of \$500.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.siscobenefits.com">www.siscobenefits.com</a> or by calling 1-844-631-6104.	Generic drugs (Tier 1)	Retail: \$10 <a href="#">copay</a> / prescription Mail Order: \$20 <a href="#">copay</a> / prescription		Prescriptions are subject to the medical Annual <a href="#">in-network deductible</a> . Covers up to a 30-day supply at a retail pharmacy for one <a href="#">copay</a> , a 31 to 60 day supply for two times the listed <a href="#">copay</a> , or 61 to 90-day supply for three times the listed <a href="#">copay</a> . Up to a 90-day supply may be purchased through mail order for the <a href="#">copay</a> listed. If a brand name drug is purchased when a generic is available, you will be responsible for the brand name <a href="#">copay</a> and the difference in cost between the brand name 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: \$35 <a href="#">copay</a> / prescription Mail Order: \$70 <a href="#">copay</a> / prescription		
	Non-preferred brand drugs (Tier 3)	Retail: \$70 <a href="#">copay</a> / prescription Mail Order: \$150 <a href="#">copay</a> / prescription		
	<a href="#">Specialty drugs</a> (Tier 4)	Not covered		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-emergency use of the emergency room is not covered.

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)	
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of \$500.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required for inpatient services; if not obtained eligible expenses will be payable at 50% to a maximum penalty of \$500.
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	Not covered	Certain routine prenatal care if billed separate from global fee is included in the Preventive Care benefit. <a href="#">Pre-certification</a> is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. If not obtained a penalty of 50% to a maximum \$500 will apply.
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of \$500. Limited to 40 visits per plan year.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	Office and Other Outpatient: Limited to 60 visits per plan year for physical, occupational, and speech therapies combined. Inpatient: Limited to 60 consecutive days per condition.
	<a href="#">Habilitation services</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 30 visits per plan year for physical, occupational, and speech therapies combined.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of \$500. Limited to 60 days per plan year
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required for all rentals and purchases above \$500, if not obtained eligible expenses will be payable at 50% to a

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)	
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	maximum penalty of \$500 —————none—————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Certain vision screening for children is included in the <a href="#">preventive care</a> 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](#).)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> <li>• Routine eye care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Specialty Drugs</li> <li>• Weight Loss Programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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|--|---|---|
| <ul style="list-style-type: none"> <li>• Chiropractic Care (limited to 12 visits per plan year)</li> </ul> | <ul style="list-style-type: none"> <li>• Habilitation Services</li> <li>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Coverage provided outside the United States. See <a href="http://www.siscobenefits.com">www.siscobenefits.com</a></li> </ul> |
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**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](http://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](http://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? 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 1-844-631-6104.

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

**French Creole (franse kreyòl):** Pou assistans 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.

**Portuguese (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.

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*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](#) \$3,000
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$3,320
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$6,350</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$1,050
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,270</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

This EXAMPLE event includes services like:

- [Emergency room](#) care (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,795
Copayments	\$5
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>