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 1-800-457-4726 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?	$6,650 / individual or $13,300 / 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 is 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 network providers $6,650 / individual or $13,300 / family; for out-of-network providers $8,650 / individual or $17,300 / 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?	Penalties for non-certification and non-emergency use of the emergency room, 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 an in-network provider?	Yes. See www.cigna.com or call 1-800-457-4726 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	0% coinsurance	20% coinsurance	None
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% 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)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	CT/PET scans, MRI, MRA requires pre-certification; if not obtained, benefits will be reduced by 50% to a maximum penalty of $250.
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 1-800-457-4726.	Generic drugs (Tier 1)	0% coinsurance		Covers up to a 90-day supply.
	Preferred brand drugs (Tier 2)	0% coinsurance		
	Non-preferred brand drugs (Tier 3)	0% coinsurance		
	Specialty drugs (Tier 4)	0% coinsurance		Specialty drugs are limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance		$250 penalty for non-emergency use of the emergency room. Out-of-Network you will pay 20% coinsurance for non-emergency use of the emergency room.
	Emergency medical transportation	0% coinsurance	20% coinsurance	None
	Urgent care	0% coinsurance	20% coinsurance	None

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)	0% coinsurance	20% coinsurance	Pre-certification is required. If you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	None
	Inpatient services	0% coinsurance	20% coinsurance	Pre-certification is required. If you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Charges related to the pregnancy of a dependent child are not covered, except for certain preventive services. Services must be pre-certified for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay; if you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Pre-certification is required. If you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
	Rehabilitation services	0% coinsurance	20% coinsurance	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	20% coinsurance	Pre-certification is required. If you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
	Durable medical equipment	0% coinsurance	20% coinsurance	Pre-certification is required for all rentals and purchases over $500. If you don't get pre-certification, benefits will be reduced by 50% to a maximum penalty of $250.
	Hospice services	0% coinsurance	20% coinsurance	None

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 your child needs dental or eye care	Children's eye exam	0% coinsurance	20% coinsurance	Certain vision screening for children is 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
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- 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.)

- Chiropractic Care
- Coverage provided outside the United States. See www.siscobenefits.com.
- Routine eye care (annual eye exam)

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 www.dol.gov/ebsa/healthreform. 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 1-800-457-4726. 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 1-800-457-4726 or the 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 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 1-800-457-4726.
Korean (한국어): 한국어로 도움을 받으려면 1-800-457-4726로 전화하십시오
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-457-4726.
Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-800-457-4726.
Arabic (عربى): للحصول على المساعدة في اللغة العربية، والدعوة 1-800-457-4726.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-4726.
French (français): Pour obtenir de l'aide en français, composez le 1-800-457-4726.
Persian (فارسی): برای کمک در فارسی، 1-800-457-4726 تماس بگیرید.
Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-800-457-4726.
Amharic (አማርኛ)]: በአማርኛ እርዳታ ለማግኘት 1-800-457-4726 ይደውሉ.
Urdu (اردو): اردو میں مدد کے لیے، 1-800-457-4726 پر کال کریں.
Yoruba (yorùbá): Fun iranlowo ni Yorùbá, pe 1-800-457-4726.
Hindi (हिंदी): **हिंदी में सहायता के लिए**, 1-800-457-4726 **पर कॉल करें**
German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-800-457-4726.
French Creole (franse kreyòl): Pou asistans nan franse kreyòl, rele 1-800-457-4726.

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	$6,650
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	$6,700

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

The plan's overall deductible	$6,650
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	$6,700

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

The plan's overall deductible	$6,650
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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