This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description at www.SodexoBenefitsCenter.com or by calling 1-855-668-5040.

Important Questions	Answers	Why this Matters:
What is the overall annual deductible?	For in-network services: **$1,000** per member up to a cumulative maximum of **$2,000** per family. For out-of-network services: **$2,000** per member up to a cumulative maximum of **$4,000** per family.	You must pay all the costs up to the **deductible** amount before this Plan begins to pay for covered services you use. Check your Summary Plan Description to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Does not apply to preventive care and in-network office visits. Copayments do not count towards the **deductible**.
Are there other Deductibles for specific services?	No.	You don't have to meet **deductibles** for specific separate services, but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out–of–pocket limit on my expenses?	For in-network services: **$5,000** per member up to a cumulative maximum of **$12,700** per family; includes deductible, copays and coinsurance For out-of-network services: **$10,000** per member up to a cumulative maximum of **$30,000** per family; includes deductible, copays and coinsurance	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This includes eligible medical and prescription costs. The limit helps you Plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, medical or prescription drug penalties, and health care for services this Plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the Plan pays?	No.	The chart starting on page 2 describes any limits on what the Plan will pay for *specific* covered services, such as office visits.

Does this Plan use a network of providers?	Yes. For a list of in-network providers, see www.myCigna.com or call 1-800-909-2227.	If you use an in-network doctor or other health care **provider**, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this Plan pays different kinds of **providers**.
Do I need a referral to see a Specialist?	No. You don't need a referral to see a Specialist.	You can see the **Specialist** you choose without permission from this Plan.
Are there services this Plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 7. See your Summary Plan Description for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the Plan's **allowed amount** for an overnight hospital stay is $1,000; your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the Plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This Plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit	50% coinsurance	Coverage for chiropractic care is limited to 30 days per year. Coverage for acupuncture is limited to 10 days per year. There are no in-network deductible requirements.
	Specialist visit	$50 copay / visit	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic tests/Lab work	No charge after the $30 copay for PCP or $50 for Specialist office visit; 30% coinsurance after deductible for hospital outpatient; 100% covered at independent lab	50% coinsurance	No charge for routine diagnostic tests as part of preventive care.
	X-rays	No charge after the $30 copay for PCP or $50 for Specialist office visit; 30% coinsurance after deductible for hospital outpatient	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	No charge after the $30 copay for PCP or $50 for Specialist office visit; 30% coinsurance after deductible for hospital outpatient	50% coinsurance	For certain out-of-network imaging services, a $500 penalty applies if not **preauthorized**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs	$10 copay (retail); $20 copay (mail)	Not covered	Retail is limited to 30-day supply. Mail order is limited to 90-day supply. After 3 prescription fills of maintenance medications at retail pharmacy, a 100% penalty applies. Mandatory generic rules apply for non-specialty drugs. For Brand name and Specialty formulary drugs minimum copay is $35 and maximum copay is $100 for retail, and minimum copay is $87.50 and maximum copay is $200 for mail order. For Brand name and Specialty non-formulary drugs minimum copay is $50 and maximum copay is $150 for retail, and minimum copay is $125 and maximum copay is $300 for mail order. Some specialty medications require member to use mail order at first fill or a 100% penalty will apply. In accordance with formulary guidelines, certain drugs may not be covered.
	Brand name formulary	10% coinsurance (mail and retail)	Not covered	
	Brand name non-formulary	30% coinsurance (mail and retail)	Not covered	
	Specialty drugs	Same as brand name, as applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance. Surgery done in physician's office 100% covered, after applicable office visit copay	50% coinsurance	For out-of-network services, a $500 penalty applies if not **preauthorized**.
	Physician/ surgeon fees	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$150 copay /visit (waived if admitted) plus 30% coinsurance	$150 copay / visit (waived if admitted) plus 30% coinsurance	——————none——————
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$30 copay / visit	$30 copay / visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay, then 30% coinsurance	$250 copay, then 50% coinsurance	For out-of-network services, a $500 penalty applies if not **preauthorized**.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 Specialist copay; 30% coinsurance for other outpatient services	50% coinsurance	For out-of-network services, a $500 penalty applies if not **preauthorized** for admission to hospital, non-hospital residential facility or intermediary facility.
	Mental/Behavioral health inpatient services	$250 copay, then 30% coinsurance	$250 copay, then 50% coinsurance	
	Substance use disorder outpatient services	$50 Specialist copay; 30% coinsurance for other outpatient services	50% coinsurance	
	Substance use disorder inpatient service	$250 copay, then 30% coinsurance	$250 copay, then 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	$30 copay PCP or $50 Specialist/first visit	50% coinsurance	After initial **copayment**, global maternity fee covers

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	$250 copay, then 30% coinsurance	$250 copay, then 50% coinsurance	basic prenatal and postnatal care and is covered at 100%. For out-of-network services, a $500 penalty applies if not **preauthorized**.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	For out-of-network services, a $500 penalty applies if not **preauthorized**. Limited to 120 days/year.
	Rehabilitation services	$30 copay PCP or $50 Specialist/visit	50% coinsurance	Physical, occupational, cognitive, and speech therapy each limited to 30 days/year. Pulmonary and cardiac rehabilitation each limited to 60 days/year.
	Habilitation services	Not covered	Not covered	––––––––––none––––––––––
	Skilled nursing care	30% coinsurance	50% coinsurance	For out-of-network services, a $500 penalty applies if not **preauthorized**. Limited to 60 days/year.
	Durable medical equipment	30% coinsurance	50% coinsurance	A $500 penalty applies if not **preauthorized**.
	Hospice service	30% coinsurance	30% coinsurance	**Deductible** is waived.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Vision eye chart tests are covered under Preventive Services
	Glasses	Not covered	Not covered	––––––––––none––––––––––
	Dental check-up	Not covered	Not covered	––––––––––none––––––––––

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Summary Plan Description for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Habilitative services
- Hearing aids (discounts available)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs (coaching to assist with weight loss is available through the Plan)

Other Covered Services (This isn't a complete list. Check your Summary Plan Description for other covered services and your costs for these services.)

- Acupuncture (up to 10 days/year)
- Bariatric surgery (one surgery/lifetime and must be in-network provider/facility)
- Chiropractic care (up to 30 days/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (up to 120 days/year)

Your Rights to Continue Coverage:

If you lose coverage under the Plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the Plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan at 1-855-668-5040. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your Plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer Service at 1-800-909-2227**.**

You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html**.**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health Plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Service:

Spanish (Español): Para obtener asistencia en Español, llame al número de teléfono en su tarjeta de identificación.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-855-668-5040.

——To see examples of how this Plan might cover costs for a sample medical situation, see the next page.——

About these Coverage Examples:

These examples show how this Plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different Plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this Plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,620
- **Patient pays** $2,920

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$320
Coinsurance	$1,450
Limits or exclusions	$150
Total	**$2,920**

Total amounts shown are based on subscriber only coverage.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- Plan pays $3,340
- Patient pays $2,060

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$660
Coinsurance	$320
Limits or exclusions	$80
Total	**$2,060**

Total amounts shown are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you will pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending accounts (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.