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 including your plan's Summary plan description, call the Administrative Office (Wilson-McShane Corp) at 1-800-622-8780. 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.dol.gov/ebsa/healthreform or call the Administrative Office at 1-800-622-8780 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers and Out-of-Network Providers combined per calendar year: $400/individual; $1,200/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 performed by network providers, network provider office visits, the first $300/accident benefit, dental and vision care, and outpatient 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?	Yes, $100/individual per calendar year for dental plan benefits. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Plan Network Provider: $5,000/individual; $10,000/family per calendar year. Out-of-Network Provider: No out-of-pocket limit. Outpatient prescription drugs: $1,600/individual; $3,200/family per calendar year.	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?	For the Medical Plan: Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, dental & vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), treatment for infertility and TMJ syndrome, and out-of-network cost sharing (except an ER visit in case of an emergency or services protected by the No Surprises Act). The prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan, dental plan or vision plan expenses, plus drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cignasharedadministration.com or call 1-800-768-4695 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?	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
		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	$20 copayment/office visit. Deductible does not apply. All other services performed and billed during an office visit: 20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of certain injectable drugs and transplant services is required to avoid a $250 penalty.
	Specialist visit	$20 copayment/office visit. Deductible does not apply. All other services performed and billed during an office visit: 20% coinsurance.	50% coinsurance plus balance billing.	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance plus balance billing.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. 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.	50% coinsurance plus balance billing.	Physician/provider's professional fees may be billed separately.

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 have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of certain outpatient radiology imaging studies (like CT, MRI, PET scans) is required to avoid a $250 penalty. Physician/provider's professional fees may be billed separately.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycigna.com. or call CIGNA pharmacy at 1-800-244-6224.	Generic drugs	Retail Pharmacy for 30-day supply: $5 copayment per prescription or 25% coinsurance whichever is greater; 90-day at Retail or Mail Order for 90-day supply: $10 copayment per prescription. No charge for FDA-approved generic contraceptives.	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and file a claim with CIGNA Pharmacy for reimbursement, then Plan reimburses billed charges minus your appropriate cost sharing.	• Deductible does not apply. • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Mandatory Generics: If you purchase a brand drug when a generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and generic drug. • Certain preventive over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit. • 90-day supply of medication at a Retail pharmacy locations available at CVS, Target, Walmart and Kroger/Frys. See also: https://www.cigna.com/individuals-families/member-resources/90-day-network.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: $20 copayment per prescription or 25% coinsurance whichever is greater; 90-day at Retail or Mail Order for 90-day supply: $40 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: $40 copayment per prescription or 50% coinsurance whichever is greater; 90-day at Retail or Mail Order for 90-day supply: $80 copayment per prescription.		
	Specialty drugs	For up to a 30-day supply: Generic drug: You pay 5% coinsurance to a max of $75 per prescription. Brand drug: You pay 5% coinsurance to a max of $150 per prescription.	Not covered.	• Deductible does not apply. • Specialty drugs require preauthorization (to avoid non-payment) by calling CIGNA Pharmacy at 1-800-244-6224. • Mandatory Generics: If you purchase a brand drug when a generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and generic drug.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of certain outpatient surgeries, spinal procedures and injectable drugs is required to avoid a $250 penalty.
	Physician/ surgeon fees	20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of certain outpatient surgeries, spinal procedures and injectable drugs is required to avoid a $250 penalty.
If you need immediate medical attention	Emergency room care	20% coinsurance plus a $250 copayment/visit.	20% coinsurance plus a $250 copayment/visit.	Physician/provider's professional fees may be billed separately. Copayment waived if admitted from ER to the hospital.
	Emergency medical transportation	20% coinsurance.	20% coinsurance plus balance billing.	Balance Billing will not apply to covered air ambulance services.
	Urgent care	20% coinsurance plus a $100 copayment/visit.	50% coinsurance plus balance billing.	Physician/provider's professional fees may be billed separately. Copayment waived if admitted from urgent care to the hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of elective hospital admission, transplant services and gene therapy services are required to avoid a $250 or non-payment penalty. Private room payable only if medically necessary or the hospital only has private rooms.
	Physician/ surgeon fees	20% coinsurance.	50% coinsurance plus balance billing.	Preauthorization of elective hospital admission is required to avoid a $250 penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copayment per office visit. Deductible does not apply. All other services performed and billed during an office visit: 20% coinsurance. Other outpatient services: 20% coinsurance.	50% coinsurance plus balance billing.	None.
	Inpatient services	20% coinsurance.	Hospital: 50% coinsurance plus balance billing. Residential treatment facility: Not covered.	Preauthorization of elective hospital admission and residential treatment program admission is required to avoid a $250 penalty. You pay 100% for out-of-network residential treatment.

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 are pregnant	Office visits	Female employee, spouse, or daughter: No charge for office visits and ACA-required preventive services. Deductible does not apply.	For employee and spouse: 50% coinsurance plus balance billing.	• Cost sharing does not apply for network preventive services. • Depending on the type of services, coinsurance may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • In-Network prenatal care (other than office visits and ACA-required preventive screening) is not covered for dependent children. Out-of-Network office visits and maternity care is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse: 20% coinsurance.	For employee and spouse: 50% coinsurance plus balance billing.	• **You must pay 100%, even in-network, for delivery expenses for a dependent child.** • Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery facility services	For employee and spouse: 20% coinsurance.	For employee and spouse: 50% coinsurance plus balance billing.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	50% coinsurance plus balance billing.	Plan covers part-time or intermittent skilled nursing care. Maximum benefit is 100 visits/calendar year.
	Rehabilitation services	20% coinsurance.	Outpatient visits: 50% coinsurance plus balance billing. Inpatient Rehab. Admission: Not covered.	Preauthorization of inpatient rehabilitation or habilitation facility admission is required to avoid a $250 penalty. You pay 100% for an out-of-network inpatient rehabilitation admission. Habilitation services (combined in and out-of-network limit): • Outpatient: 60 visits/person per calendar year • Inpatient: 60 days/person per calendar year. Limits do not apply to treatment of mental health conditions.
	Habilitation services			
	Skilled nursing care	20% coinsurance.	Not covered.	Preauthorization of skilled nursing facility admission is required to avoid a $250 penalty. Maximum benefit is 60 days/calendar year. You pay 100% for an out-of-network inpatient skilled nursing facility admission.
	Durable medical equipment	20% coinsurance.	50% coinsurance plus balance billing.	No charge from network providers for breastfeeding pump and supplies needed to operate pump.

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)	
	Hospice services	20% coinsurance.	Home hospice: 20% coinsurance plus balance billing. Inpatient hospice: Not covered.	Covered if terminally ill. Preauthorization of inpatient hospice is required to avoid a $250 penalty. You pay 100% for an out-of-network inpatient hospice admission.
If your child needs dental or eye care	Children's eye exam	For individuals under 18 years, no charge. Medical plan deductible does not apply. For individuals age 18 and older, no charge up to $32.50/exam. You pay costs over $32.50/exam. Medical plan deductible does not apply.		One eye exam per 12 consecutive months. One frame per 24 consecutive months. One pair of lenses per 12 months. There is no vision network. If you elect vision coverage, it will be available under a separate vision plan. Your cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	You pay 100% and submit your claim for reimbursement. Plan reimburses up to $50/frame and up to $25/single lens. You pay any amount over $50/frame and $25/single lens. Medical plan deductible does not apply.		
	Children's dental check-up	No charge. Medical plan and dental plan deductibles do not apply.		There is no dental network. If you elect dental coverage, it will be available under a separate dental plan. Your cost sharing for dental services does not count toward the medical plan's out-of-pocket limit.

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
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs, except as required by health reform law

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

- Chiropractic care (payable up to 12 visits/calendar year).
- Dental care (Adult), (if you elect dental plan coverage, it is payable up to $1,000/calendar year for Plan A and $1,500/calendar year for Plan C)
- Infertility treatment (you pay 20% coinsurance after deductible up to $10,000 per couple per lifetime, thereafter you pay 90% coinsurance.)
- Routine eye care (Adult) (if you elect the separate vision plan coverage)
- Routine foot care (covered when treating diabetes, neurological or vascular insufficiency affecting the feet)

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Administrative Office (Wilson-McShane Corp) at 1-800-622-8780, 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. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-622-8780.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-622-8780.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-622-8780.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-622-8780.

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** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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	$400
Copayments	$0
Coinsurance	$2,160
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,580**

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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	$120
Copayments	$120
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,390**

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

- **The plan's overall deductible** **$400**
- **Specialist copayment** **$20**
- **Hospital (facility) ER copayment + coinsurance** **$250 +20%**
- **Other coinsurance** **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	$400
Copayments	$330
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,090**

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