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, go to www.cigna.com/sp/ or call 1-800-Cigna24. Call 1-800-234-3375 for Delta Dental. 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 http://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have an overall deductible.
Are there other deductibles for specific services?	Yes. $75 / individual / $150 / family for dental coverage (waived if in-network provider). 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?	For in-network providers $2,000 individual / $4,000 family; for out-of-network providers $2,500 individual / $5,000 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?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization (where required), 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.myCigna.com or call 1-800-Cigna24 for a list of in-network providers. Call 1-800-234-3375 for dental 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.

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	50% coinsurance	70% coinsurance	A $40 charge / phone call or online visit applies to Retail Telehealth Services through Amwell or MDLIVE until the out-of-pocket limit has been met. These charges count toward the out-of-pocket limit. Services for COVID-19 testing and diagnosis (including Retail Telehealth Services through Amwell or MDLIVE) will be covered at 100%.
	Specialist visit	50% coinsurance	70% coinsurance	Chiropractic care is limited to $800 / family per calendar year.
	Preventive care/screening/ immunization	50% coinsurance	70% coinsurance	Covers flu shots and any vaccine intended to prevent or mitigate COVID-19 at 100%.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	70% coinsurance	Covers COVID-19 testing at 100%. Preauthorization is required for certain outpatient diagnostic testing and procedures. *See Article III, Section D.2. If you don't get preauthorization, benefits could be denied.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	70% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	50% coinsurance (retail & mail order)	50% coinsurance	Covers up to a 34-day supply or 100-day supply of a maintenance medication (retail prescription); 90-day supply (mail order prescription). Certain limitations may apply. *See Article III, Section E.
	Preferred brand drugs (Tier 2)	50% coinsurance (retail & mail order)	50% coinsurance	
	Non-preferred brand drugs (Tier 3)	50% coinsurance (retail & mail order)	50% coinsurance	
	Specialty drugs	50% coinsurance (retail & mail order)	50% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	50% coinsurance	70% coinsurance	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	50% coinsurance	
	Urgent care	50% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan.

If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	70% coinsurance	For a private room, the most common daily semi-private room rate. Preauthorization is required for certain non-routine services. *See Article III, Section D. 3. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	50% coinsurance	70% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	70% coinsurance	Preauthorization is required. *See Article III, Section D. 3. If you don't get preauthorization, benefits could be denied.
	Inpatient services	50% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
If you are pregnant	Office visits	50% coinsurance	70% coinsurance	None
	Childbirth/delivery professional services	50% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Childbirth/delivery facility services	50% coinsurance	70% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	70% coinsurance	None
	Rehabilitation services	50% coinsurance	70% coinsurance	Speech therapy limited to 90 days / calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	50% coinsurance	70% coinsurance	None
	Durable medical equipment	50% coinsurance	70% coinsurance	None
	Hospice services	50% coinsurance	70% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to $600 / family per calendar year.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge	No charge	Limited to $1,500 / individual per calendar year. Benefits provided by Delta Dental. You are responsible for charges above the reasonable and customary charge for a check-up by an out-of-network provider.

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
- Habilitation Services
- Hearing Aids (other than bone-anchored)
- Infertility
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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 • Dental Care (Delta Dental)	• Immunizations • Routine Eye Care	• Routine Foot Care

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: Department of Labor 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 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: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor 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. Contact the Kansas Insurance Department at 800-432-2484 or http://www.ksinsurance.org.

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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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 coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,055

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

The plan's overall deductible	$0
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$963
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$963

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