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 online at www.cigna.com/sp. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Endeavor Health Network in-network providers: $1,650/individual-employee only or $3,300/family maximum For in-network providers: $4,000/individual - employee only or $8,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	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 Endeavor Health Network in-network providers: $7,000/individual-employee only or $14,000/family maximum (no more than $7,000 per individual - within a family) For in-network providers: $8,050/individual - employee only or $16,100/family maximum (no more than $8,050 per individual - within a family) Combined medical/behavioral and pharmacy out-of-pocket limit	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, 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.cigna.com or call 1-800-233-7137 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
		Endeavor Health Network	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	10% coinsurance/visit	30% coinsurance/visit	Not covered	None
	Specialist visit	10% coinsurance/visit	30% coinsurance/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. 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)	10% coinsurance	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$15 copay (30 day retail) $25 copay (90 day retail or mail)	$15 copay (30 day retail) $45 copay (90 day CVS retail)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Endeavor Health Network	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.express-scripts.com or by calling 1-800-766-5373.	Preferred brand drugs (Tier 2)	20% coinsurance (30 day retail minimum of $50 and maximum of $80) 20% coinsurance (90 day retail or mail minimum of $85 and maximum of $150)	30% coinsurance (30 day retail minimum of $70 and maximum of $120) 25% coinsurance (90 day CVS retail minimum of $125 and maximum of $225)	Not covered	You must obtain maintenance long term medications and 90 day fills from either CVS or Endeavor Health Pharmacies (mail or retail). Combined medical and Rx oral and injectable fertility drugs lifetime maximum of $30,000 Weight-loss GLP1s have a separate $200 copay for 30 day supply. Must be filled at an Endeavor Health pharmacy and member must meet requirements. You must obtain Specialty drugs at an Endeavor Health pharmacy unless LDD or approved exception.
	Non-preferred brand drugs (Tier 3)	30% coinsurance (30 day retail minimum of $80 and maximum of $150) 30% coinsurance (90 day retail or mail minimum of $160 and maximum of $225)	40% coinsurance (30 day retail minimum of $100 and maximum of $200) 35% coinsurance (90 day CVS retail minimum of $250 and maximum of $300)	Not covered	
	Specialty drugs (Tier 4)	$50 copay Generic (30 day retail) $150 copay Preferred (30 day retail) $250 copay Non-Preferred (30 day retail)	Exception only	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	10% coinsurance	Out-of-network services are paid at the in-network cost share and deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Endeavor Health Network	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	10% coinsurance	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance/office visit 10% coinsurance/all other services	10% coinsurance/office visit 10% coinsurance/MDLIVE visit 10% coinsurance/all other services	Not covered	Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance	10% coinsurance	Not covered	Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Endeavor Health Network	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Not covered	Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	10% coinsurance/PCP visit 10% coinsurance/ Specialist visit	30% coinsurance/PCP visit 30% coinsurance/ Specialist visit	Not covered	Coverage is limited to annual max of: 90 days for Rehabilitation services; 36 days for Cardiac rehab services; 20 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	10% coinsurance/PCP visit 10% coinsurance/ Specialist visit	30% coinsurance/PCP visit 30% coinsurance/ Specialist visit	Not covered	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	10% coinsurance	30% coinsurance	Not covered	Coverage is limited to 120 days annual max.
	Durable medical equipment	Not Covered	10% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Endeavor Health Network	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	10% coinsurance /inpatient services 10% coinsurance /outpatient services	10% coinsurance/inpatient services 10% coinsurance/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Acupuncture (12 days)
- Bariatric surgery
- Chiropractic care (20 days)
- Hearing aids
- Private-duty nursing (70 visits/8 hours per shift)
- Infertility treatment (Lifetime max $30,000)

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: Cigna at 1-800-Cigna24, 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: Cigna Customer service at 1-800-Cigna24. 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. Contact: Illinois Department of Insurance at (877) 527-9431.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*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** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,650
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,780

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,650
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$2,240

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$1,650
Copayments	$10
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,760

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

Plan Name: Qualified High Deductible Health Plan (HDHP) HDHPQ **Ben Ver:** 32 **Plan ID:** 32779789