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 1-877-505-4161 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.	See the Common Medical Events chart below for your costs for services this plan covers.
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?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-877-505-4161 for a list of network providers.	This plan uses a provider network.
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	Not covered	Not covered	None
	Specialist visit	Not covered	Not covered	See mental/behavioral health and substance abuse disorder section
	Preventive care/ screening/ immunization	Not covered	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Not covered	Not covered	None
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need immediate medical attention	Emergency room care	Not covered	Not covered	None
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	Not covered	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/STC - Short Term Counseling; Not covered/other Services	Not covered	Coverage is limited to annual max of: 7 visits per issue
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	Not covered	Not covered	None
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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
- Chiropractic Care
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Emergency medical transportation
- Emergency room services
- Eye care (Children)
- Facility Fees
- Habilitation services
- Hearing aids
- Home Health Care
- Hospice services
- Infertility treatment
- Laboratory Services
- Long-term care
- Mental/Behavioral health inpatient and outpatient services
- Non-emergency care when traveling outside the U.S.
- Other practitioner office visit
- Physician/surgeon fees
- Prescription drugs
- Prenatal/postnatal/delivery inpatient services for pregnancy
- Primary care services
- Private-duty nursing
- Radiological services
- Rehabilitation services
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing
- Specialist services
- Substance use disorder inpatient and outpatient services
- Urgent Care
- Weight loss programs

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

- Short Term Counseling (7 visits; per issue)

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: Nevada Department of Business and Industry at 1-888-872-3234 and 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 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 or the Nevada Department of Business and Industry at 1-888-872-3234. Additionally, a consumer assistance program can help you file your appeal. Contact: Office of Consumer Health Assistance at (888) 333-1597.

Does this plan provide Minimum Essential Coverage? **No**
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? **No**
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	**N/A**
Specialist coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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

The plan's overall deductible	**N/A**
Specialist coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

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

The plan's overall deductible	**N/A**
Specialist coinsurance	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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

Plan Name: Williams-Sonoma, Inc. - Short Term Counseling (STC)