Summary of Benefits and Coverage: *What this Plan Covers & What You Pay For Covered Services* — **Coverage Period:** *01/01/2026 - 12/31/26*

Plan Name: CIGNA HDHP-2 Medical Plan — **Coverage for:** *Individual + Family* | **Plan Type:** *PPO*

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, contact Sage TPA at 1-855-959-5956. 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.*

Important Questions	Answers	Why This Matters:
What is the overall deductible?	*Network Provider: $4,500 Per Plan Participant $9,000 Per Family Unit Non-Network $9,000 Per Plan Participant $18,000 Per Family Unit*	*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*	*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?	*Network Provider: $7,000 Per Plan Participant $9,100 Per Family Unit Non-Network $14,000 Per Plan Participant $28,000 Per Family Unit*	*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, Pre-service review penalties, balance-billing charges (unless balance-billing is prohibited), and health care this plan doesn't cover.*	*Yes OOP limit applies: 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. For a list of providers, see https://mycigna.com or call 1-855-929-5956*	*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	PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information*
	Primary care visit to treat an injury or illness	*20% coinsurance*	*50% coinsurance*	*The office visit copayment applies once per visit and includes the exam and supplies when performed on the same day, by the same provider, and regardless of an office visit charge.*

If you visit a health care provider's office or clinic	*Specialist visit*	*20% coinsurance*	*50% coinsurance*	
	Preventive care/screening/ immunization	*No Charge*	*50% coinsurance*	*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)*	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required for Diagnostic and Therapeutic radiology to avoid a penalty.*
	Imaging (CT/PET scans, MRIs)	*20% coinsurance after deductible*	*50% coinsurance*	
If you need drugs to treat your illness or condition *More information about prescription drug coverage is available at www.affirmedrx.com*	*Generic drugs*	*20% coinsurance*	*40% coinsurance*	*Deductible does not apply to prescription drug coverage.* *One copayment per 30-day supply, up to a 90-day supply.* *Standard Formulary applies. Certain Women's Preventative Services will be covered with no cost to the member.*
	Preferred brand drugs	*20% coinsurance*	*40% coinsurance*	
	Non-preferred brand drugs	*20% coinsurance*	*40% coinsurance*	
	Specialty drugs	*N/A*	*N/A*	
If you have outpatient surgery	*Facility fee (e.g., ambulatory surgery center)*	*20% coinsurance*	*50% coinsurance*	
	Physician/surgeon fees	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty.*
If you need immediate medical attention	*Emergency room care*	*20% coinsurance*	*50% coinsurance*	
	Emergency medical transportation	*20% coinsurance*	*20% coinsurance*	*None*
	Urgent care	*20% coinsurance*	*50% coinsurance*	*None*
If you have a hospital stay	*Facility fee (e.g., hospital room)*	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty.*
	Physician/surgeon fees	*20% coinsurance*	*50% coinsurance*	
If you need mental health, behavioral health, or substance abuse services	*Outpatient services (Facility and Physician)*	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty.*
	Office Visits (includes outpatient therapy)	*20% coinsurance*	*50% coinsurance*	*The office visit copayment applies once per visit and includes the exam and supplies when performed on the same day, by the same provider, and regardless of an office visit charge.*
	Inpatient services	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty.*
If you are pregnant	*Office visits*	*20% coinsurance*	*50% coinsurance*	*Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).*
	Childbirth/delivery professional services	*20% coinsurance*	*50% coinsurance*	
	Childbirth/delivery facility services	*20% coinsurance*	*50% coinsurance*	
	Home health care	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty. Limited to 60 visits per Calendar Year.*

If you need help recovering or have other special health needs	Rehabilitation services	*20% coinsurance* *OMT/Chiropractic/Manipulation 10% coinsurance*	*50% coinsurance* *OMT/Chiropractic/Manipulation 30% coinsurance*	*Physical Therapy limited to 30 visits per Calendar Year. Occupational Therapy and Speech Therapy limited to 20 visits per therapy per Calendar Year. Cardiac Rehabilitation limited to 36 visits per Calendar Year. Post Cochlear Implant Aural Therapy limited to 20 visit per Calendar Year.*
	Habilitation services	*See Rehabilitation Services above.*		
	Skilled nursing care	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty. Limited to 60 visits per Calendar Year.*
	Durable medical equipment	*20% coinsurance ; No cost share to member if sourced through Connect DME*	*50% coinsurance*	*None*
	Hospice services	*20% coinsurance*	*50% coinsurance*	*Pre-Service Review Required to avoid a penalty.*
If your child needs dental or eye care	*Children's eye exam*	*No Charge*	*50% coinsurance*	*Limited to one exam every 2 years for Plan Participants age 19 and older. Under age 19 no limit on*
	Children's glasses	*Not Covered*		*None*
	Children's dental check-up	*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*
- *Cosmetic surgery*
- *Infertility Treatment*
- *Long-Term Care*
- *Routine foot Care*
- *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*
- *Hearing Aids*

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: For group health coverage subject to ERISA, contact 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: For group health coverage subject to ERISA, 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 may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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

f 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 (855)-929-5956

*Footer: * For more information about limitations and exceptions, contact Sage TPA at 1-855-959-5956.*