NOTICE OF SUMMARY MATERIAL MODIFICATION

Dear Participant and Beneficiaries,

This summary of material modification ("**SMM**") describes changes to Simon Pearce (US) Inc. Medical Insurance ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Medical Insurance

Reason for SMM

- Changes that increase premiums, deductibles, coinsurance, copayments
- Modifications that narrow or expand the circumstances under which benefits are paid

Effective Date of Material Modification: 01/01/2021

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Simon Pearce (US) Inc..
Cathy Sullivan
109 Park Road, Windsor, VT 05089
cathy.sullivan@simonpearce.com
(802) 230-2431

General Plan Information:
Plan Name: Simon Pearce (US) Inc.'s Health & Welfare Benefit Plan
Plan Number: 506
Plan Sponsor/Plan Administrator: Simon Pearce (US) Inc.

SIMON PEARCE

COMPANY NAME: Simon Pearce
ADDRESS: 109 Park Road, Windsor, VT 05089
CONTACT NAME: Cathy Sullivan
PHONE NUMBER: 802-230-2431
EMAIL: csullivan@simonpearce.com
SIC CODE: 1793, Glass and Glazing Work
NAICS CODE: 327212
TAX ID: 03-0278920

2021 Account Inforce Sheet
Full Time

Coverage Type	Carrier	Renewal Date	Rates

MEDICAL:

Gold w/HRA ($750,$1,500 HRA)- 80% coinsurance - Deductible Indiv $1,800/Fam $3,600, OOPM $2,500/$5,000, Rx Copays ($5,,$20,$40,40%)
Silver w/ HSA ($20,$40,$60 HSA), 80% coinsurance; Deductible Indiv $2,800/Fam $5,600 - OOPM $5,000 /$10,000 - Rx 40% coins.
Bronze - 60% coinsurance, $50 OV Copay, Deductible Indiv $1,000/Fam $2,000 - OOPM $7,150/ $14,300, Rx Copays ($5,$20,$40,40%)

CIGNA: Level Funded *#623907*

1/1/2022 Eligible 1st of the mo after DOH. 30+ hours/ week. Spouse coverage rule.

MEDICAL

Total Monthly Premium

	Gold			Silver			Bronze			EE Bi-Weekly			2020 COBRA Rates		
	Employer	Employee	Total	Employer	Employee	Total	Employer	Employee	Total	Gold	Silver	Bronze	Gold	Silver	Bronze
Employee Only	$537.15	$166.87	$704.02	$537.15	$79.09	$616.24	$537.15	$40.92	$578.06	$77.02	$36.50	$18.88	$718.10	$628.57	$589.63
Employee + Spouse	$1,074.33	$333.72	$1,408.05	$1,074.33	$158.18	$1,232.51	$1,074.33	$81.78	$1,156.11	$154.02	$73.01	$37.74	$1,436.21	$1,257.16	$1,179.23
Employee + Child(ren)	$1,047.44	$325.44	$1,372.87	$1,047.44	$154.25	$1,201.69	$1,047.44	$79.78	$1,127.21	$150.20	$71.19	$36.82	$1,400.33	$1,225.72	$1,149.76
Employee + Family	$1,504.07	$467.24	$1,971.31	$1,504.07	$221.43	$1,725.50	$1,504.07	$114.51	$1,618.58	$215.65	$102.20	$52.85	$2,010.74	$1,760.01	$1,650.95

DENTAL:

Calendar Year Deductible Individual $25 / Family $75
Preventative 100%, Basic 80%, Major 50% & Ortho 50% up to $1,000
Calendar Year Maximum - $1,500

DELTA DENTAL: ASO *#70081*

1/1/2022 1st of the mo after DOH, 30+ hours/week

DENTAL

	Total Monthly Premium			EE Bi-Weekly	2020 COBRA Rates
Employee Only	$19.73	$14.45	$34.18	$6.67	$34.86
Employee + 1	$42.48	$28.39	$70.87	$13.10	$72.29
Employee + Child(ren)	$44.07	$30.29	$74.36	$13.98	$75.85
Employee + Family	$66.85	$45.48	$112.33	$20.99	$114.58

VISION:

100% Employee Paid
Annual eye exam $10 Copay
Glasses $25 Copay
$130 allowance for Frames or Contacts

VSP: Signature *#30045226*

1/1/2022 1st of the mo after DOH, 30+ hours/week

VISION

	Total Monthly Premium			EE Bi-Weekly	2020 COBRA Rates
Employee Only	$0.00	$8.37	$8.37	$3.86	$8.54
Employee + 1	$0.00	$13.39	$13.39	$6.18	$13.66
Employee + Child(ren)	$0.00	$13.67	$13.67	$6.31	$13.94
Employee + Family	$0.00	$22.04	$22.04	$10.17	$22.48

LIFE & AD&D:

Basic Life/AD&D - 100% of prior year w2 to a maximum of $50,000
Supplemental Life/AD&D, Dependent Life - $10K Increments up to 5x prior year w2 or $500K

RELIANCE STANDARD *#159668*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employer Funded

50% Benefit Deduction at age 70

STD:

60% of your predisability earnings up to $750 Weekly

RELIANCE STANDARD *#166463*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employee Funded

Benefit begins on the 8th day for accident & sickness

Up to 13 weeks after elimination period

LTD:

60% of your presidability earnings up to $5,000 Monthly

RELIANCE STANDARD *#130228*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employer Funded

90 Day Elimination Period

2 Year Occupation Period

ACCIDENT INSURANCE:

60% of your presidability earnings up to $6,000 Monthly

RELIANCE STANDARD *#825579*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employee Funded

CRITICAL ILLNESS:

Benefit amounts from $5,000 - $50,000 in $5,000 increments

RELIANCE STANDARD *#801434*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employee Funded

Spousal Coverage Available

Child dependents automatically enrolled @ 25% of EE coverage

Employee Benefits Center	Work United Resource Coordinator	Tuition Reimbursement Program	COBRA - csONE
ThinkHR	Wellness/Health Programs: Cigna - $10,000		Student Loan Assitance - GradFin
Compliance Dashboard	bswift - benefit administration	Employee Product Savings/Discounts	

The Richards Group

SIMON PEARCE

COMPANY NAME: Simon Pearce
ADDRESS: 109 Park Road, Windsor, VT 05089
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SIC CODE: 1793, Glass and Glazing Work
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2021 Account Inforce Sheet
Part Time

Coverage Type	Carrier	Renewal Date	Rates

MEDICAL:

Gold w/HRA ($750,$1,500 HRA)- 80% coinsurance - Deductible Indiv $1,800/Fam $3,600, OOPM $2,500/$5,000, Rx Copays ($5,,$20,$40,40%)
Silver w/ HSA ($20,$40,$60 HSA), 80% coinsurance; Deductible Indiv $2,800/Fam $5,600 - OOPM $5,000 /$10,000 - Rx 40% coins.
Bronze - 60% coinsurance, $50 OV Copay, Deductible Indiv $1,000/Fam $2,000 - OOPM $7,150/ $14,300, Rx Copays ($5,$20,$40,40%)

CIGNA: Level Funded *#623907*

1/1/2022 Eligible 1st of the mo after DOH. 30+ hours/ week. Spouse coverage rule.

MEDICAL

Total Monthly Premium

	Gold			Silver			Bronze			EE Bi-Weekly			2020 COBRA Rates		
	Employer	Employee	Total	Employer	Employee	Total	Employer	Employee	Total	Gold	Silver	Bronze	Gold	Silver	Bronze
Employee Only	$537.15	$333.74	$704.02	$537.15	$158.19	$616.24	$537.15	$81.83	$578.06	$154.03	$73.01	$37.77	$718.10	$628.57	$589.63
Employee + Spouse	$1,074.33	$667.43	$1,408.05	$1,074.33	$316.37	$1,232.51	$1,074.33	$163.56	$1,156.11	$308.05	$146.02	$75.49	$1,436.21	$1,257.16	$1,179.23
Employee + Child(ren)	$1,047.44	$650.87	$1,372.87	$1,047.44	$308.51	$1,201.69	$1,047.44	$159.55	$1,127.21	$300.40	$142.39	$73.64	$1,400.33	$1,225.72	$1,149.76
Employee + Family	$1,504.07	$934.49	$1,971.31	$1,504.07	$442.86	$1,725.50	$1,504.07	$229.02	$1,618.58	$431.30	$204.40	$105.70	$2,010.74	$1,760.01	$1,650.95

DENTAL:

Calendar Year Deductible Individual $25 / Family $75; Preventative 100%,
Preventative 100%, Basic 80%, Major 50% & Ortho 50% up to $1,000
Calendar Year Maximum - $1,500

DELTA DENTAL: ASO *#70081*

1/1/2022 1st of the mo after DOH, 30+ hours/week

DENTAL

	Total Monthly Premium			EE Bi-Weekly	2020 COBRA Rates
Employee Only	$0.00	$34.18	$34.18	$15.78	$34.86
Employee + 1	$0.00	$70.87	$70.87	$32.71	$72.29
Employee + Child(ren)	$0.00	$74.36	$74.36	$34.32	$75.85
Employee + Family	$0.00	$112.33	$112.33	$51.84	$114.58

VISION:

100% Employee Paid
Annual eye exam $10 Copay
Glasses $25 Copay
$130 allowance for Frames or Contacts

VSP: Signature *#30045226*

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	Total Monthly Premium			EE Bi-Weekly	2020 COBRA Rates
Employee Only	$0.00	$8.37	$8.37	$3.86	$8.54
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Employee + Child(ren)	$0.00	$13.67	$13.67	$6.31	$13.94
Employee + Family	$0.00	$22.04	$22.04	$10.17	$22.48

ACCIDENT INSURANCE:

60% of your presidability earnings up to $6,000 Monthly

RELIANCE STANDARD *#825579*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employee Funded

CRITICAL ILLNESS:

Benefit amounts from $5,000 - $50,000 in $5,000 increments

RELIANCE STANDARD *#801434*

1/1/2022 1st of mo after DOH, 30+ Hours

100% Employee Funded

Spousal Coverage Available

Child dependents automatically enrolled @ 25% of EE coverage

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 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$1,800**/individual or **$3,600**/family Amount your employer contributes to your account - Up to **$750**/individual or **$1,500**/family. **Deductible applies to all benefits unless otherwise noted**.	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. In-network preventive care, prescription drugs.	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 in-network providers: $2,500/individual or $5,000/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 1-866-494-2111 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
		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	20% coinsurance/visit	Not covered	None
	Specialist visit	20% coinsurance/visit	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **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)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance at an outpatient facility 20% coinsurance in the office	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$5 copay/prescription (retail 30 days), $15 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail 30 days), $60 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail 30 days), $120 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
	Specialty drugs (Tier 4)	40% coinsurance/prescription (retail & home delivery 30 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	Not covered	None
	Inpatient services	20% coinsurance	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 are pregnant	Office visits	20% coinsurance	Not covered	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	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 40 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	20% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 20% coinsurance/visit for Chiropractic care	Not covered	Coverage is limited to an annual max of 90 visits for Physical therapy, Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance	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:

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- 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.)

- Bariatric surgery
- Chiropractic care (20 visits)

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'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, you can contact Cigna Customer service at 1-866-494-2111. 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: Vermont Division of Financial Regulation at (800) 964-1784. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------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	**$1,800**
Specialist coinsurance	**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	$1,800
Copayments	$10
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,530**

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

The plan's overall deductible	**$1,800**
Specialist coinsurance	**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	$1,140
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	**$1,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**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	$1,800
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,010**

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

Plan Name: HRA OAPIN Gold **Ben Ver:** 18 **Plan ID:** 10707247

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2,800**/individual or **$5,600**/family **Deductible applies to all benefits unless otherwise noted** Combined medical/behavioral and pharmacy deductible	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. In-network preventive care, in-network generic preventive drugs.	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 in-network providers: **$5,000**/individual or **$10,000**/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 1-866-494-2111 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
		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	20% coinsurance/visit	Not covered	None
	Specialist visit	20% coinsurance/visit	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **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)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance at an outpatient facility 20% coinsurance in the office	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	40% coinsurance/prescription (retail and home delivery)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	40% coinsurance/prescription (retail and home delivery)	Not covered	
	Non-preferred brand drugs (Tier 3)	40% coinsurance/prescription (retail and home delivery)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	Not covered	None
	Inpatient services	20% coinsurance	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 are pregnant	Office visits	20% coinsurance	Not covered	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	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 40 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	20% coinsurance/visit for Physical, Speech, Hearing & Occupational therapy 20% coinsurance/visit for Chiropractic care	Not covered	Coverage is limited to an annual max of 90 visits for Physical therapy, Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance	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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- 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.)

- Bariatric surgery
- Chiropractic care (20 visits)

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'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, you can contact Cigna Customer service at 1-866-494-2111. 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: Vermont Division of Financial Regulation at (800) 964-1784. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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 1-866-494-2111.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------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** **$2,800**
- **Specialist coinsurance** **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	$2,800
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$4,820**

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

- **The plan's overall deductible** **$2,800**
- **Specialist coinsurance** **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	$2,800
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

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

- **The plan's overall deductible** **$2,800**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Plan Name: HDHPQ OAPIN Silver **Ben Ver:** 18 **Plan ID:** 10708226

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 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $1,000/individual or $2,000/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. In-network preventive care, office visits, prescription drugs, emergency room visits, urgent care facility visits.	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 in-network providers: $7,150/individual or $14,300/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.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-866-494-2111 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.

Important Questions	Answers	Why This Matters:
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	$50 copay/visit Deductible does not apply	Not covered	None
	Specialist visit	$50 copay/visit Deductible does not apply	Not covered	None
	Preventive care/ screening/immunization	No charge/visit** No charge/other services** No charge/immunizations** **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)	40% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance at an outpatient facility 40% coinsurance in the office	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$5 copay/prescription (retail 30 days), $15 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail 30 days), $60 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$40 copay/prescription (retail 30 days), $120 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
	Specialty drugs (Tier 4)	40% coinsurance/prescription (retail & home delivery 30 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$250 copay/visit Deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/office visit** 40% coinsurance/all other services **Deductible does not apply	Not covered	None
	Inpatient services	40% coinsurance	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 are pregnant	Office visits	40% 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	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Coverage is limited to 40 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$50 copay/visit for Physical, Speech, Hearing & Occupational therapy $50 copay/visit for Chiropractic care	Not covered	Coverage is limited to an annual max of 90 visits for Physical therapy, Speech, Hearing & Occupational therapy and 20 visits annual max for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	40% coinsurance	Not covered	Coverage is limited to 60 days annual max.
	Durable medical equipment	40% coinsurance	Not covered	None
	Hospice services	40% coinsurance	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:

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- 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.)

- Bariatric surgery
- Chiropractic care (20 visits)

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'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, you can contact Cigna Customer service at 1-866-494-2111. 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: Vermont Division of Financial Regulation at (800) 964-1784. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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:
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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

----------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	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$1,000
Copayments	$60
Coinsurance	$4,600
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5,680**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$940**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$980
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,480**

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

Plan Name: Sold 2021 Simon Pearce Baseline Bronze **Ben Ver:** 18 **Plan ID:** 10699069