Dear DAVIS Employee,

The Davis Companies is committed to keeping you healthy and covered! We are proud to offer two health insurance benefit plans for 2020. We are offering a Bronze MVP plan from CIGNA and a Minimum Essential Coverage Plus (MEC) plan from PHCS/Multiplan.

We are offering individual and family level coverage for both plans. Eligibility for enrollment in these programs is determined based on working full-time hours on a regular basis.

The deadline to enroll is by your 90th day of employment with DAVIS. Coverage for either plan begins on your 91st day.

The cost for the CIGNA MVP Bronze plan will be:
Individual (single) plan for 2020 will cost 9.78% of your weekly wages, but not to exceed $114.39 per week. This amount will be deducted from your paycheck on a weekly pre-tax basis.

For example, on an individual plan, if in a given week you work 40 hours and make $11 per hour, for a weekly total gross pay of $440 the cost of Cigna insurance to you would be:
$440.00 x 9.78% = $43.03 per week
Your rate will vary weekly depending on the amount you make each week.

MVP Bronze Family Coverage is also available for an <u>additional</u> election of $314.57 per week, but not to exceed $428.96 per week.

Deductible Amount		Maximum Out of Pocket Cost (In-Network)
Individual	$3,000	$6,350
Family	$6,000	$12,700

The CIGNA MVP Bronze program is comparable to a bronze level plan available through the national Health Insurance Marketplace.

The cost for the Minimum Essential Coverage Plus (MEC) plan will be:
Individual (single) Plan: $62.10 per week
Family Plan: $269.08 per week

Your insurance premium for the MEC plan will be deducted from your paycheck on a weekly pre-tax basis.

Deductible Amount	Maximum Out of Pocket Cost (In-Network)
Individual $0	$1,850
Family $0	$12,700

Please Note that the MEC Plus plan has several exclusions which are not covered by the plan including hospital inpatient services and mental/behavioral health services. For Massachusetts employees only – the MEC plan does not meet the state's criteria for minimal essential coverage for individuals under Massachusetts law.

To enroll in coverage, or find out additional information please email benefits@daviscos.com , or call Joann Ducharme at 508-305-6000 and the benefits team will assist you.

Additional information about both plans can be found on http://daviscos.com/employee-resources/

The DAVIS Companies

2020 DAVIS Contractor Benefits Summary

Health Insurance for DAVIS Employees

The DAVIS Companies is committed to keeping you healthy and covered! DAVIS is proud to offer two health insurance plans through Sisco who is a benefit administrator for CIGNA. These plans are available to our employees and their dependents and also comply with the standard requirements of the Affordable Care Act. The plans we are offering are the Bronze MVP Plan and the Minimum Essential Coverage Plus (MEC) Plan.

Full-time employees are eligible to enroll in this program after 60 days of service with DAVIS. You have until your 90th day of employment to enroll or waive your election of this benefit, and coverage begins on your 91st day of employment.

You will not receive any further communications about these insurance options, so if you are interested in enrolling after two months on assignment, please email benefits@daviscos.com or call 508-305-6025 to speak to DAVIS Human Resources to enroll.

Should you choose to enroll in either plan, weekly contributions will be deducted from your paycheck on a pre-tax basis.

*****Please note: If you do not enroll in health insurance by your 90th day of employment, you will not be able to enroll in health insurance until the annual open enrollment period, which typically occurs in November or December for a January 1 effective coverage date.******

Coverage for the Bronze MVP plan includes (in-network):

- 100% of preventive care
- Annual physicals
- Immunizations
- Routine gynecological screenings, including mammograms
- Routine colonoscopies
- Age appropriate routine screenings/tests
- Fitness club membership reimbursements
- Access to thousands of doctors in the CIGNA network and more!

Coverage for the Minimum Essential Coverage Plus (MEC) includes (in-network):

- 100% of preventive care
- Annual physicals
- Immunizations
- Routine gynecological screenings, including mammograms
- Routine colonoscopies
- Age appropriate routine screenings/tests
- Prescription coverage

***Please note that the MEC Plus Plan does not cover certain procedures including but not limited to: inpatient or chronic disease hospital care, emergency ambulance, outpatient surgery, well newborn care during enrolled mother's maternity admission, and inpatient mental hospital/substance abuse facility care. **For Massachusetts employees only – the MEC plan does not meet the state's criteria for minimal essential coverage for individuals under Massachusetts law.**

Additional information about the plans:

SISCO Benefits
www.siscobenefits.com
Phone: 844-631-6104

Eligibility to Enroll: Enrollment begins on 60th day of employment for coverage effective on 91st day of employment.
You will receive an email from The Davis Companies at your 55th day of employment notifying you of your eligibility to enroll in health insurance.

Enroll or decline health insurance coverage please email benefits@daviscos.com and we will work to get you set up in the enrollment system.

Plan Choice 1: MVP Bronze Plan

Bronze Plan – Single or Family
Deductible (in-network):
Individual/Single: $3,000
Family: $6,000

Annual Out of Pocket Max:
Individual/Single: $6,350
Family: $12,700

Cost:

Individual/Single: Your weekly gross wages x 9.78%
For example: If you make $25/hour, and work 40 hours per week, your gross pay would be $1000. $1000 x 0.0978 = $97.80 per week for health insurance

****Your rate will vary weekly depending on the amount you make each week.****
There is a cap on the weekly rate for a single plan at $114.39 per week.

Family Plan Weekly Cost: your individual rate +$314.57/week
(From above example $97.80 + $314.57= $412.37/week)
There is a cap on the weekly rate for a family plan at $428.96 per week

Your Personal Member ID is located on your Insurance Card.

Plan Choice 2: Minimum Essential Coverage Plus (MEC) (PHCS/Multiplan)

Deductible (in-network): $0 for both individual and family plan

Annual Out of Pocket Max:
Single/Individual: $1,850
Family: $12,700

Cost:
Single/Individual: $62.10 per week
Family: $170.77 per week

For other health insurance plans in your home state *not* affiliated with DAVIS, please visit: www.healthcare.gov

Prescriptions

CastiaRX
www.castiaRx.com
Phone: 866-516-3121
BIN Number: 800010
PCN: LDI
Rx Group: 37001
***Your Personal Member ID is located on your Blue Benefit Insurance Card
Mail Order Available – You get 3 months of prescriptions for the cost of 2 months!

401k Plan with Company Match

Voya Financial
https://voyaretirement.voyaplans.com/eportal/welcome.do
Phone: 800-584-6001
Plan Name: The Davis Companies 401k Plan
Plan #: 815172

Eligibility to Enroll: Must be 21 years old, and have worked at least 30 days at Davis. Then you may enroll at the next open enrollment date.
Open Enrollment Dates: January 1, April 1, July 1, October 1

401k Davis Match:
After one (1) year of service, if you work at least 1000 hours in your first twelve (12) months at Davis, or if you work at least 1000 hours in subsequent calendar years, Davis matches 25% up to 4% of your salary contribution.

401k Match Vesting Schedule:
Less than 1 year of service at Davis - 0%
1 year but less than 2 – 25%
2 years but less than 3 – 50%
3 years but less than 4 – 75%
4 years or more – 100%

Direct Deposit/iPay (to view your paystubs)

https://ipay.adp.com/iPay/login.jsf
Registration Code: daviscos-pays
Username: first initial, last name @ daviscos (for example, John Smith is jsmith@daviscos)

Holiday Pay Policy

After working a total of 1800 regular hours (45 weeks full time), you are eligible to be paid for time off on four (4) of the approved list of holidays. Holidays are paid as eight (8) hour days, regardless of normal work schedule. For every additional 400 regular hours worked, employee is eligible for one (1) additional eight (8) hour paid holiday. There can be no gap in service of more than 4 consecutive weeks.
Approved Holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas

If an employee wants to take Holiday Pay, you must contact your Davis recruiter one week before the holiday and request the time off. Recruiters will process the holiday time separately from your timecard, so paid holiday time should not be included on your normal weekly timesheet.

Massachusetts Earned Sick Time Policy (only for employees who work in Massachusetts)

Beginning on July 1, 2015, you will accrue one (1) sick hour for every 30 hours that you work. Earned Sick Time may be used for:

- If you, your child, spouse or parent-in-law is sick, has a medical appointment, travel time to and from medical appointments, and to address the effects of domestic violence.

You will be able to use any accrued paid sick time on or after your 90th day of employment. You may accrue up to 40 hours of earned sick time per policy year (July 1-June 30). Any unused time may be rolled over to the next calendar year but employees cannot take more than 40 hours of sick time in one policy year. Earned sick time may be used upon return of up to a one (1) year absence in work. Earned sick time will not be paid out upon the end of an assignment.

If you would like to use your earned sick time, please contact your Davis recruiter to find out how much time you have accrued. Do not include any sick time on your timecard, as your Davis recruiter will process that time separately from your regular hours worked.

New Jersey Earned Sick Time Law (only for employees who work in NJ)

All employees who work in New Jersey can earn and use up to 40 hours of paid sick time per policy year. This time is intended to be used when the employee is unable to work when:

- You need diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or you need preventive medical care;
- You need to care for a family member during diagnosis, care, treatment, or recovery for a mental or physical illness, injury, or health condition; or your family member needs preventative medical care;
- You or a family member have been the victim of domestic violence or sexual violence and need time for treatment, counseling, or to prepare for legal proceedings;
- You need to attend school-related conferences, meetings, or events regarding your child's education; or to attend school-related meetings regarding your child's health; or

- Your employer's business closes due to a public health emergency or you need to care for a child whose school or child care provider closed due to a public health emergency.

Employees will earn one (1) hour of sick time for every 30 hours worked and begin accruing those hours on the date of hire. Employees may begin to use their earned sick time on the 120th day after hire or when the employee has worked the equivalent number of hours to equal 120 days (960 hours). Earned sick time will be compensated at the same hourly rate that the employee normally is paid.

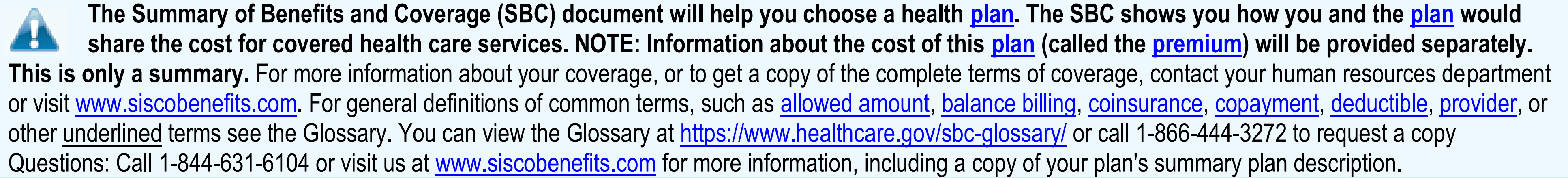
The DAVIS Companies' policy year for tracking purposes is July 1-June 30 for all employees who are not covered by the aforementioned PTO policy. Employees can carry over up to 40 hours of unused sick time to the next policy year but cannot use more than 40 hours in a policy year. Unused sick time will not be paid out to the employee at assignment end or termination but will remain in their bank for up to six (6) months post separation for use in the event of re-employment.

Employees may be required to provide reasonable documentation if the absence is for more than 24 consecutively scheduled work hours, or three (3) consecutive work shifts. Not calling and not showing up for more than 24 consecutive work hours or more than three (3) scheduled work shifts may be grounds for disciplinary action, up to and including termination. Employees must make a good faith effort to notify DAVIS in advance if the need for earned sick time is foreseeable. If you would like to use earned sick time, we ask that you contact your manager with as much notice as possible. For scheduled appointments, we ask for at least two (2) days' notice if possible. In the event that you cannot notify us, then we ask that a responsible adult notifies us on your behalf. After you have notified your manager of your intention to use earned sick time, your manager will inform you of how much time you have in your bank and have available to you. In addition, your manager will handle the processing of your sick time hours. These will be paid in your normal biweekly paycheck.

All employees who are covered under our Full-Time Employee Paid Time Off Policy will receive the sick time benefit as listed in the PTO policy, as this is a more generous offering than the State of New Jersey requires. Part-Time Employees working in New Jersey will only be eligible for the required 40 hours per year of Paid Sick Time. For clarification purposes, employees will not be eligible for an additional 40 hours of Earned Paid Sick Time.

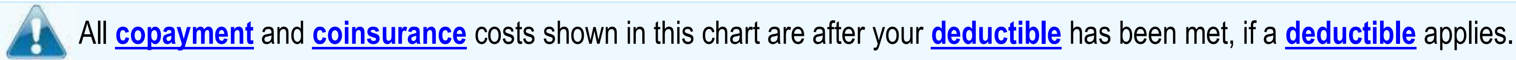
***All Benefits and Rate information is subject to change at any time, with or without notice, subject to state and federal laws.

Davis Corporate Services – Bronze MVP Plan



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 your human resources department or visit www.siscobenefits.com. 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 1-866-444-3272 to request a copy
Questions: Call 1-844-631-6104 or visit us at www.siscobenefits.com for more information, including a copy of your plan's summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $3,000 / individual or $6,000 / family; for out-of-network providers: Not covered.	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 services are covered before you meet your deductible.	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: $6,350 / individual or $12,700 / family; for out-of-network providers: Not covered.	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?	Pre-certification penalties, 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 an in-network provider?	Yes. See www.mycigna.com or call 1-844-631-6104 for a list of 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.


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	40% coinsurance	Not covered	None
	Specialist visit	40% coinsurance	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need 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	Not covered	Pre-certification is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.siscobenefits.com or by calling 1-844-631-6104.	Generic drugs (Tier 1)	Retail: $10 copay / prescription Mail Order: $20 copay / prescription		Prescriptions are subject to the medical Annual in-network deductible. Covers up to a 30-day supply at a retail pharmacy for one copay, a 31 to 60 day supply for two times the listed copay, or 61 to 90-day supply for three times the listed copay. Up to a 90-day supply may be purchased through mail order for the copay listed. If a brand name drug is purchased when a generic is available, you will be responsible for the brand name copay and the difference in cost between the brand name and generic drug. If your physician indicates that only the name brand may be taken, this limitation will not apply.
	Preferred brand drugs (Tier 2)	Retail: $35 copay / prescription Mail Order: $70 copay / prescription		
	Non-preferred brand drugs (Tier 3)	Retail: $70 copay / prescription Mail Order: $150 copay / prescription		
	Specialty drugs (Tier 4)	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

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 immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Non-emergency use of the emergency room is not covered.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	40% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Pre-certification is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500.
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	Not covered	Pre-certification is required for inpatient services; if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500.
	Inpatient services	40% coinsurance	Not covered	
If you are pregnant	Office visits	40% coinsurance	Not covered	Certain routine prenatal care if billed separate from global fee is included in the Preventive Care benefit. Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay. If not obtained a penalty of 50% to a maximum $500 will apply.
	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	Pre-certification is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500. Limited to 40 visits per plan year.
	Rehabilitation services	40% coinsurance	Not covered	Office and Other Outpatient: Limited to 60 visits per plan year for physical, occupational, and speech therapies combined. Inpatient: Limited to 60 consecutive days per condition.
	Habilitation services	40% coinsurance	Not covered	Limited to 30 visits per plan year for physical, occupational, and speech therapies combined.
	Skilled nursing care	40% coinsurance	Not covered	Pre-certification is required; if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500. Limited to 60 days per plan year

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)	
	Durable medical equipment	40% coinsurance	Not covered	Pre-certification is required for all rentals and purchases above $500, if not obtained eligible expenses will be payable at 50% to a maximum penalty of $500
	Hospice services	40% coinsurance	Not covered	————————none————————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Certain vision screening for children is included in the preventive care benefit.
	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
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care
- Routine Foot Care
- Specialty Drugs
- 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 (limited to 12 visits per plan year)
- Habilitation Services
- Hearing Aids
- Coverage provided outside the United States. See www.siscobenefits.com

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your human resources department for information about continuing your coverage; visit www.siscobenefits.com to find a copy of your plan; or call SISCO at 1-844-631-6104. 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: SISCO at 1-844-631-6104 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-844-631-6104.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-631-6104.
Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-844-631-6104.
Korean (한국어): 한국어로 도움을 받으려면 1-844-631-6104로 전화하십시오
Tagalog (Tagalog – Filipino): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-631-6104.
Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-844-631-6104.
Arabic (عربي): للحصول على المساعدة في اللغة العربية، والدعوة 1-844-631-6104.
French Creole (franse kreyòl): Pou asistans nan franse kreyòl, rele 1-844-631-6104.
French (français): Pour obtenir de l'aide en français, composez le 1-844-631-6104.
Polish (UWAGA): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-631-6104.
Portugese (português): Para obter assistência em português, ligue para 1-844-631-6104.
Italian (italiana): Per assistenza in lingua italiana, chiamare 1-844-631-6104.
German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-844-631-6104.
Japanese （日本語）： 日本語の場合は1-844-631-6104までご連絡ください。
Persian (فارسی): برای کمک در فارسی، 1-844-631-6104 تماس بگیرید.

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** **$3,000**
- **Specialist coinsurance** **40%**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$4,300
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$6,350**

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

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **40%**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$800
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$3,800**

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

- **The plan's overall deductible** **$3,000**
- **Specialist coinsurance** **40%**
- **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)*

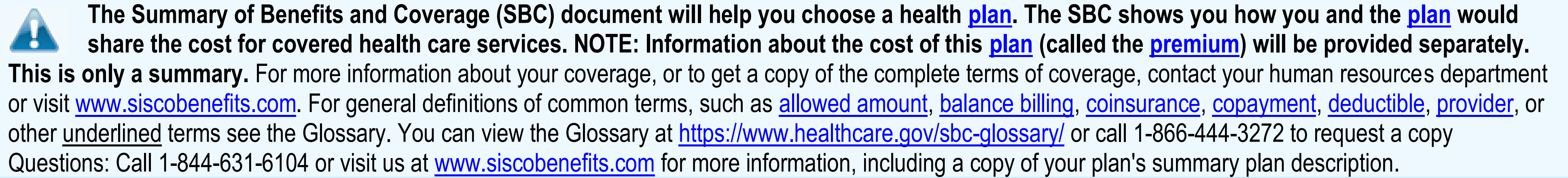
Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Davis Corporate Services – MEC Plus Plan



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 your human resources department or visit www.siscobenefits.com. 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 1-866-444-3272 to request a copy
Questions: Call 1-844-631-6104 or visit us at www.siscobenefits.com for more information, including a copy of your plan's summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0 / individual or $0 / family; for out-of-network providers: $500 / individual or $1,000 / 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. Prescription drugs are covered before you meet your deductible.	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: $3,000 / individual or $12,700 / family; for out-of-network providers: Unlimited	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?	Pre-certification penalties, 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 an in-network provider?	Yes. See www.multiplan.com or call 1-844-631-6104 for a list of 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.

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	$15 copay / visit	60% coinsurance	Applies to visit charge only.
	Specialist visit	$25 copay / visit	60% coinsurance	Applies to visit charge only.
	Preventive care/screening/ immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay / service	60% coinsurance	Services in the emergency room limited to a $1,500 maximum payment per visit for all services combined.
	Imaging (CT/PET scans, MRIs)	$400 copay / service	60% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.siscobenefits.com or by calling 1-844-631-6104.	Generic drugs (Tier 1)	Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription		Deductible does not apply to prescriptions. Covers up to a 30-day supply at a retail pharmacy for one copay, a 31 to 60 day supply for 2 times the listed copay or 61 to 90-day supply for 3 times the listed copay. Up to a 90-day supply may be purchased through mail order for the copay listed. If a name brand drug is purchased when a generic is available, you will be responsible for the name brand copay and the difference in cost between the name brand and generic drug. If your physician indicates that only the name brand may be taken, this limitation will not apply.
	Preferred brand drugs (Tier 2)	Retail: $25 copay / prescription Mail Order: $62.50 copay / prescription		
	Non-preferred brand drugs (Tier 3)	Retail: $75 copay / prescription Mail Order: $187.50 copay / prescription		
	Specialty drugs (Tier 4)	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	$400 copay / visit	$400 copay / visit	Limited to a $1,500 maximum payment per visit for all services combined. Copay applies to the in-network out-of-pocket limit. Non-emergency use of the emergency room is not covered.
	Emergency medical	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	transportation			
	Urgent care	$50 copay / visit	60% coinsurance	Applies to visit charge only.

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 have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay / visit; Other: Not covered	Not covered	Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	$15 copay / visit	60% coinsurance;	Applies to visit charge only. Certain routine prenatal care if billed separate from global fee is included in the Preventive care benefit.
	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	Office: $25 copay / visit; Other: Not covered	Not covered	Limited to 60 visits per plan year for physical, occupational, and speech therapies combined. Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	Habilitation services	Office: $25 copay / visit; Other: Not covered	Not covered	Limited to 30 visits per plan year for physical, occupational, and speech therapies combined. Limited to service in a Provider's Office. Services provided elsewhere are not covered.
	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	Certain vision screenings for children are included in the preventive care benefit.
	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 • Cosmetic Surgery • Dental Care • Durable Medical Equipment • Emergency Medical Transportation • Hearing Aids	• Home Health Care • Hospice Services • Infertility Treatment • Inpatient Hospital Services • Long Term Care • Non-emergency care when traveling outside the U.S.	• Outpatient Surgery • Private Duty Nursing • Routine eye care • Routine Foot Care • Skilled Nursing Care • Specialty Drugs • 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 (limited to 12 visits per plan year)	• Habilitation Services (limited to 30 office visits per plan year)	• Coverage provided outside the United States. See www.siscobenefits.com

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your human resources department for information about continuing your coverage; visit www.siscobenefits.com to find a copy of your plan; or call SISCO at 1-844-631-6104. 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: SISCO at 1-844-631-6104 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? 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 1-844-631-6104.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-631-6104.

Vietnamese (tiếng Việt): Để được trợ giúp bằng tiếng Việt, xin gọi 1-844-631-6104.

Korean (한국어): 한국어로 도움을 받으려면 1-844-631-6104로 전화하십시오

Tagalog (Tagalog – Filipino): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-631-6104.

Russian (русский): Для получения помощи на русском языке позвоните по телефону 1-844-631-6104.

Arabic (عربى): للحصول على المساعدة في اللغة العربية، والدعوة 1-844-631-6104.

French Creole (franse kreyòl): Pou asistans nan franse kreyòl, rele 1-844-631-6104.

French (français): Pour obtenir de l'aide en français, composez le 1-844-631-6104.

Polish (UWAGA): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-631-6104.

Portugese (português): Para obter assistência em português, ligue para 1-844-631-6104.

Italian (italiana): Per assistenza in lingua italiana, chiamare 1-844-631-6104.

German (Deutsch): Für Hilfe in Deutsch, rufen Sie 1-844-631-6104.

Japanese （日本語）： 日本語の場合は1-844-631-6104までご連絡ください。

Persian (فارسی): برای کمک در فارسی، 1-844-631-6104 تماس بگیرید.

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 copayment	**$25**
Hospital (facility) coinsurance	**NA**
Other coinsurance	**NA**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,550
The total Peg would pay is	**$11,950**

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 copayment	**$25**
Hospital (facility) coinsurance	**NA**
Other coinsurance	**NA**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,800**

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

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**NA**
Other coinsurance	**NA**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$700
The total Mia would pay is	**$1,150**

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