



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 employer. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary>.

| Important Questions                                                             | Answers                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$3,400 Individual / \$6,800 Family for In-Network<br>\$4,000 Individual / \$8,000 Family for Out-of-Network<br><a href="#">Deductible</a> is embedded.            | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In-Network <a href="#">preventive care</a> and services covered at “No charge”.                                                                               | This <a href="#">plan</a> covers some items and services even if you haven’t yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                | You don’t have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$6,800 Individual / \$13,300 Family for In-Network<br>\$8,000 Individual / \$16,000 Family for Out-of-Network<br><a href="#">Out-Of-Pocket Limit</a> is embedded. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, Pre-Certification penalties, and health care this <a href="#">plan</a> doesn’t cover.          | Even though you pay these expenses, they don’t count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.cigna.com">CIGNA.com</a> for a list of <a href="#">network providers</a>                                                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan’s <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider’s charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

Benefits and cost sharing accumulate on a Calendar Year basis.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies, unless otherwise stated.

| Common Medical Event                                                                                                                                                                                        | Services You May Need                                  | What You Will Pay                                                                       |                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                             |                                                        | In-Network Provider<br>(You will pay the least)                                         | Out-of-Network Provider<br>(You will pay the most)               |                                                                                                                                                                                                                                       |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                               | Primary care visit to treat an injury or illness       | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                             | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                             | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                               | Not Covered                                                      | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.                          |
| <b>If you have a test</b>                                                                                                                                                                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification is required on imaging. \$500 penalty applies if not obtained.                                                                                                                                                      |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.phoenixpbm.com">www.phoenixpbm.com</a> | Generic drugs                                          | Retail: 0% <a href="#">coinsurance</a> / prescription after <a href="#">deductible</a>  | Not covered                                                      | Prior authorization may be required on certain <a href="#">prescription drugs</a> .                                                                                                                                                   |
|                                                                                                                                                                                                             | Preferred brand drugs                                  | Retail: 25% <a href="#">coinsurance</a> / prescription after <a href="#">deductible</a> | Not covered                                                      |                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                             | Non-preferred brand drugs                              | Retail: 45% <a href="#">coinsurance</a> / prescription after <a href="#">deductible</a> | Not covered                                                      | Benefits may vary if more than a 30-day supply is needed.                                                                                                                                                                             |
|                                                                                                                                                                                                             | <a href="#">Specialty drugs</a>                        | 30% <a href="#">coinsurance</a> / prescription after <a href="#">deductible</a>         | Not covered                                                      | Specialty drugs with a gross cost of \$2,500 per month are covered by when coordinated with the PBM's Patient Advocacy Program. The Plan may permit for at least one (1) 30-day fill for each of these drugs during the Benefit Year. |
| <b>If you have outpatient surgery</b>                                                                                                                                                                       | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification required on surgical procedures. \$500 penalty applies if not obtained.                                                                                                                                             |
|                                                                                                                                                                                                             | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                        | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                                                                                                                  |

\* For more information about limitations and exceptions, see the plan document.

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                |                                                                  | Limitations, Exceptions, & Other Important Information                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)                  | Out-of-Network Provider<br>(You will pay the most)               |                                                                                                                                                    |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Same as In-Network                                               | \$500 penalty for non-urgent services.                                                                                                             |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Same as In-Network                                               | None                                                                                                                                               |
|                                                                           | <a href="#">Urgent care</a>                      | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Same as In Network                                               | None                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification required. \$500 penalty applies if not obtained.                                                                                 |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None.                                                                                                                                              |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification is required on inpatient services. \$500 penalty applies if not obtained.                                                        |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                               |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | None                                                                                                                                               |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. \$500 penalty applies if not obtained. |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification required. \$500 penalty applies if not obtained. 60 visits/Calendar Year.                                                        |
|                                                                           | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Physical, speech, occupational cardiac rehabilitation limited to 35 visits per Calendar Year combined.                                             |
|                                                                           | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> |                                                                                                                                                    |
|                                                                           | <a href="#">Skilled nursing care</a>             | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification required. \$500 penalty applies if not obtained. 25 days/ Calendar Year.                                                         |
|                                                                           | <a href="#">Durable medical equipment</a>        | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification applies to DME, Orthotics, and Prosthetics. \$500 penalty applies if not obtained.                                               |

\* For more information about limitations and exceptions, see the plan document.

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                |                                                                  | Limitations, Exceptions, & Other Important Information                                                        |
|----------------------------------------|----------------------------------|------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
|                                        |                                  | In-Network Provider<br>(You will pay the least)                  | Out-of-Network Provider<br>(You will pay the most)               |                                                                                                               |
|                                        | <a href="#">Hospice services</a> | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> | 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Pre-Certification required for inpatient. \$500 penalty applies if not obtained. 15 visits/days per lifetime. |
| If your child needs dental or eye care | Children's eye exam              | No Charge                                                        | Not Covered                                                      | Coverage limited to one exam per Calendar Year                                                                |
|                                        | 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](#).)**

- |                                                                                                                                                         |                                                                                                                                                                                           |                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

- Chiropractic care (25 visits per Plan year)

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 your employer or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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 1-855-699-5433.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-699-5433.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-699-5433.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-699-5433.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,200        |
| Copayments                        | \$0            |
| Coinsurance                       | \$1,800        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,060</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$3,200        |
| Copayments                        | \$0            |
| Coinsurance                       | \$400          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,620</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

This EXAMPLE event includes services like:

Emergency Department: Facility (*including medical supplies*)  
Diagnostic Services (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,800        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |