



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, please visit our website at www.iiv.compusysut.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.iiv.compusysut.com or call 1-888-867-9510 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 person/\$1,000 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventative</u> care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See list of covered preventative services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$25 per person <u>deductible</u> for dental coverage (except preventative care).	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$7,900 individual (\$6,120 medical and \$1,780 prescription drug) and \$15,800 per family (\$12,240 medical and \$3,560 prescription drug) effective January 1, 2020. For <u>network providers</u> \$7,900 individual (\$6,120 medical and \$1,780 prescription drug) and \$15,800 per family (\$12,240 medical and \$3,560 prescription drug) effective January 1, 2021.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family out-of-pocket limit has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Balance-billed charges, non-covered charges, charges in excess of allowable amounts, and penalties for failure to obtain <u>preauthorization</u> of services. In addition, the cost between a chosen brand and generic equivalent does not count toward the <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes (select OAP). See www.CIGNAsharedadministration.com , www.CIGNA.com or at 1-800-768-4695 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes. Hearing aids must be <u>preauthorized</u> .	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the <u>plan's</u> permission before you see the <u>specialist</u> .

[* For more information about limitations and exceptions, see the plan or policy document at www.iiv.compusysut.com.]



All [copayments](#) shown in this chart are taken before 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
		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	\$30 copay	40% coinsurance after deductible met.	Out of network providers covered at 80% coinsurance if outside PPO geographic service area. Applies to covered plan benefits only. See Plan Booklet for What is Not Covered. Telehealth or virtual visits are also a covered benefit.
	Specialist visit	\$30 copay	40% coinsurance after deductible met.	
	Preventive care/screening/immunization	No charge	Not covered – You pay 100% of the charges	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible met.	40% coinsurance after deductible met.	Applies to covered plan benefits only. No out-of-pocket expense for COVID-19 testing.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iiv.compusysut.com	Generic drugs (Tier 1)	\$10 retail; \$20 mail order	You pay 100%. You can submit your claim for reimbursement to the Plan's Pharmacy Benefit Manager.	34 day supply retail 90 day supply mail
	Preferred brand drugs (Tier 2)	15% coinsurance .		Plus difference between brand and generic is available. \$20 min and \$40 max at retail. \$50 min and \$100 max at mail order
	Non-preferred brand drugs (Tier 3)	15% coinsurance .		34 day supply retail 90 day supply mail
	Specialty drugs (Tier 4)	\$75 co-payment .		Plus difference between brand and generic is available. \$50 min and \$100 max at retail. \$100 min and \$200 max at mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is met.	40% coinsurance after deductible is met.	Preauthorization is required (\$200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Physician/surgeon fees			

[* For more information about limitations and exceptions, see the plan or policy document at www.iiv.compusysut.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	\$300 <u>co-payment</u> , then 20% <u>coinsurance</u> after <u>deductible</u> is met.	\$300 <u>co-payment</u> , then 20% <u>coinsurance</u> after <u>deductible</u> is met.	Emergency Room <u>co-payment</u> waived if admitted. Contact CareAllies within 48 hours of emergency hospital confinements or first working day after weekend admission, otherwise the Plan will reduce its reimbursements by \$200. Applies to covered <u>plan</u> benefits only.
	Emergency medical transportation	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met.	
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>co-payment</u> per admission, then 20% <u>coinsurance</u> after <u>deductible</u> is met.	\$100 <u>co-payment</u> per admission, then 40% <u>coinsurance</u> after <u>deductible</u> is met.	<u>Preauthorization</u> is required (\$200 reduction in benefits if no <u>preauthorization</u>). Applies to covered <u>plan</u> benefits only.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met (office visits only). All other outpatient services not covered.	<u>Preauthorization</u> is required (\$200 reduction in benefits if <u>preauthorization</u> requirement not met for in-network intensive outpatient). Applies to covered <u>plan</u> benefits only.
	Inpatient services	\$100 copay per admission, then 20% <u>coinsurance</u> after <u>deductible</u> is met.	Not covered.	<u>Preauthorization</u> is required (\$200 reduction in benefits if <u>preauthorization</u> requirement not met including partial hospitalization). Applies to covered <u>plan</u> benefits only.
If you are pregnant	Office visits	No charge.	40% <u>coinsurance</u> after <u>deductible</u> is met.	Applies to covered <u>plan</u> benefits only.
	Childbirth/delivery professional services	\$100 <u>co-payment</u> per admission, then 20% <u>coinsurance</u> after <u>deductible</u> is met.	\$100 <u>co-payment</u> per admission, then 40% <u>coinsurance</u> after <u>deductible</u> is met.	
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met.	Applies to covered <u>plan</u> benefits only.
	Rehabilitation services	\$100 <u>co-payment</u> per admission, then 20% <u>coinsurance</u> after <u>deductible</u> is met (inpatient). 20% <u>coinsurance</u> after <u>deductible</u> is met (outpatient).	40% <u>coinsurance</u> after <u>deductible</u> is met (outpatient). Inpatient services not covered.	<u>Preauthorization</u> is required for inpatient and speech therapy services (\$200 reduction in benefits if no <u>preauthorization</u>). Applies to covered <u>plan</u> benefits only.
	Habilitation services	Not covered.	Not covered.	You pay 100% of habilitation services.
	Skilled nursing care	\$100 <u>co-payment</u> per admission, then 20% <u>coinsurance</u> after <u>deductible</u> is met.	Not covered.	<u>Preauthorization</u> is required (\$200 reduction in benefits if no <u>preauthorization</u>). Applies to covered <u>plan</u> benefits only. Maximum benefit is 70 days per calendar year.
	Durable medical equipment	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met.	Replacement only if device is too worn for repair or change in physical condition rendering current device unusable.
	Hospice services	20% <u>coinsurance</u> after <u>deductible</u> is met.	40% <u>coinsurance</u> after <u>deductible</u> is met.	Applies to covered <u>plan</u> benefits only.
If your child needs dental or eye care	Children's eye exam	You pay for charges in excess of \$50 maximum calendar year benefit. No charge for preventative care eye exam for children under 19 years of age.		No annual maximum for children under 19 years of age.
	Children's glasses	No charge for lenses. You pay for charges in excess of \$150 for frames and \$150 for contacts in lieu of glasses.		
	Children's dental check-up	No charge for preventative care dental exam.		

[* For more information about limitations and exceptions, see the plan or policy document at www.iiw.compusysut.com.]

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](#).)

- Bariatric Surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Medically Unnecessary Care

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

- Chiropractic services to a maximum of 20 visits per year
- Acupuncture services to a maximum of 20 visits per year
- Hearing aids (see Article VI of SPD)
- Dental care (see Article VIII of SPD)
- Routine eye care (see Article VII of SPD)
- Telemedicine

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage?

This plan or policy does provide minimum essential coverage. 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 the Minimum Value Standards?

This health coverage does meet the minimum value standard for the benefits it provides. If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-432-6636.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-6636.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-432-6636.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-432-6636.]

-----*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](#) \$500
- [Specialist](#) \$30
- Hospital (facility) \$100
- Other 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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,240

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) \$30
- Hospital (facility) \$100
- Other 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	\$7,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$610
Coinsurance	\$910
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,080

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) \$30
- Hospital (facility) \$100
- Other 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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$390
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,220