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.iiw.compusysut.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 www.iiw.compusysut.com or call 1-888-867-9510 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,500 individual or $5,000 family For out-of-network providers: $5,000 individual or $10,000 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. Preventive care is 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 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 $8,150 individual ($6,310 medical and $1,840 prescription drug) and $16,300 per family ($12,620 medical and $3,680 prescription drug). For out-of-network providers $16,300 individual ($12,620 medical and $3,680 prescription drug) and $32,600 per family ($25,240 medical and $7,360 prescription drug).	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?	Balance-billed charges, non-covered charges, charges in excess of allowable amounts, and penalties for failure to obtain preauthorization of services. In addition, the cost between a chosen brand and generic equivalent does not count toward the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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

Will you pay less if you use a network provider?	Yes (select OAP). See www.CIGNAsharedadministration.com, www.CIGNA.com or at 1-800-768-4695 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Hearing aids must be preauthorized.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	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	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	Not covered – You pay 100% of the charges	Plan covers preventive services and supplies required by the Health Care Reform law. Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Applies to covered plan benefits only.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Applies to covered plan benefits only.
	COVID-19 Test	No charge	No charge	No Preauthorization required. Cost share shown will remain in effect until Secretary of HHS determines that the public health emergency has expired.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iiw.compusysut.com	Generic drugs (Tier 1)	$20 copay retail; $40 copay 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)	25% coinsurance		Plus difference between brand and generic is available. $80 min and $160 max at retail $160 min and $320 max at mail order 34 day supply retail 90 day supply mail
	Non-preferred brand drugs (Tier 3)	25% coinsurance retail; 30% coinsurance mail order		Plus difference between brand and generic is available. $160 min and $320 max at retail $320 min and $640 max at mail order 34 day supply retail 90 day supply mail
	Specialty drugs (Tier 4)	$75 copay		Only available through mail order. Preauthorization required.

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	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 plan benefits only.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance (office visits only). All other outpatient services not covered.	Preauthorization is required ($200 reduction in benefits if preauthorization requirement not met for in-network intensive outpatient). Applies to covered plan benefits only.
	Inpatient services	20% coinsurance	Not covered	Preauthorization is required ($200 reduction in benefits if preauthorization requirement not met including partial hospitalization). Applies to covered plan benefits only.
If you are pregnant	Office visits	No charge	40% coinsurance	Applies to covered plan benefits only.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	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% coinsurance	40% coinsurance	Applies to covered plan benefits only.
	Rehabilitation services	20% coinsurance (inpatient). 20% coinsurance (outpatient).	40% coinsurance (outpatient). Inpatient services not covered.	Preauthorization is required for inpatient and speech therapy services ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only.
	Habilitation services	Not covered	Not covered	You pay 100% of habilitation services.
	Skilled nursing care	20% coinsurance	Not covered	Preauthorization is required ($200 reduction in benefits if no preauthorization). Applies to covered plan benefits only. Maximum benefit is 70 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Replacement only if device is too worn for repair or change in physical condition rendering current device unusable.
	Hospice services	20% coinsurance	40% coinsurance	Applies to covered plan 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 preventive 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	Not Covered		None

[* 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.)

- Any service or supply not considered Medically Necessary
- 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

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact 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

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 1-800-432-6636.]
[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, kwiijigo holne' 1-800-432-6636.]

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$4,570

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

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$100
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,620

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

The plan's overall deductible	$2,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,570

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