



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](http://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](http://www.iiw.compusysut.com) or call 1-888-867-9510 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> : \$2,500 individual or \$5,000 family For <a href="#">out-of-network providers</a> : \$5,000 individual or \$10,000 family	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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> .	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 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> \$8,150 individual (\$6,310 medical and \$1,840 <a href="#">prescription drug</a> ) and \$16,300 per family (\$12,620 medical and \$3,680 <a href="#">prescription drug</a> ). For <a href="#">out-of-network providers</a> \$16,300 individual (\$12,620 medical and \$3,680 <a href="#">prescription drug</a> ) and \$32,600 per family (\$25,240 medical and \$7,360 <a href="#">prescription drug</a> ).	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Balance-billed charges, non-covered charges, charges in excess of allowable amounts, and penalties for failure to obtain <a href="#">preauthorization</a> of services. In addition, the cost between a chosen brand and generic equivalent does not count toward the <a href="#">out-of-pocket limit</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

[\* For more information about limitations and exceptions, see the plan or policy document at [www.iiw.compusysut.com](http://www.iiw.compusysut.com).]

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes (select OAP). See <a href="http://www.CIGNAsharedadministration.com">www.CIGNAsharedadministration.com</a>, <a href="http://www.CIGNA.com">www.CIGNA.com</a> or at 1-800-768-4695 for a list of <a href="#">network providers</a>.</p>	<p>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 <a href="#">plan's 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 <a href="#">provider's</a> 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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>Yes. Hearing aids must be <a href="#">preauthorized</a>.</p>	<p>This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have the <a href="#">plan's</a> permission before you see the <a href="#">specialist</a>.</p>



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)	
<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>	40% <a href="#">coinsurance</a>	<a href="#">Out-of-network providers</a> covered at 80% <a href="#">coinsurance</a> if outside PPO geographic service area. Applies to covered <a href="#">plan</a> benefits only. See <i>Plan Booklet</i> for What is Not Covered. Telehealth or virtual visits are also a covered benefit.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered – You pay 100% of the charges	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Applies to covered <a href="#">plan</a> benefits only.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Applies to covered <a href="#">plan</a> benefits only.
	COVID-19 Test	No charge	No charge	No <a href="#">Preauthorization</a> required. Cost share shown will remain in effect until Secretary of HHS determines that the public health emergency has expired.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.iiv.compusysut.com">www.iiv.compusysut.com</a>	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> retail; \$40 <a href="#">copay</a> mail order	You pay 100%. You can submit your claim for reimbursement to the <a href="#">Plan's</a> Pharmacy Benefit Manager.	34 day supply retail 90 day supply mail
	Preferred brand drugs (Tier 2)	25% <a href="#">coinsurance</a>		Plus difference between brand and generic is available. \$80 min and \$160 max at retail \$160 min and \$320 max at mail order
	Non-preferred brand drugs (Tier 3)	25% <a href="#">coinsurance</a> retail; 30% <a href="#">coinsurance</a> mail order		34 day supply retail 90 day supply mail
	<a href="#">Specialty drugs</a> (Tier 4)	\$75 <a href="#">copay</a>		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
				Only available through mail order. <a href="#">Preauthorization</a> 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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<p><a href="#">Preauthorization</a> is required (\$200 reduction in benefits if no <a href="#">preauthorization</a>). Applies to covered <a href="#">plan</a> benefits only.</p> <p>In some instances, services provided by an <a href="#">out-of-network provider</a> at an in-network facility may be payable at 20% <a href="#">coinsurance</a>.</p>
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<p>Contact CareAllies within 48 hours of emergency hospital confinements or first working day after weekend admission, otherwise the <a href="#">Plan</a> will reduce its reimbursements by \$200. Applies to covered <a href="#">plan</a> benefits only.</p>
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> 20% <a href="#">coinsurance</a> for Air Ambulance	
	<a href="#">Urgent care</a>			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<p><a href="#">Preauthorization</a> is required (\$200 reduction in benefits if no <a href="#">preauthorization</a>). Applies to covered <a href="#">plan</a> benefits only.</p>
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> (office visits only). All other outpatient services not covered.	<p><a href="#">Preauthorization</a> is required (\$200 reduction in benefits if <a href="#">preauthorization</a> requirement not met for in-network intensive outpatient). Applies to covered <a href="#">plan</a> benefits only.</p>
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	<p><a href="#">Preauthorization</a> is required (\$200 reduction in benefits if <a href="#">preauthorization</a> requirement not met including partial <a href="#">hospitalization</a>). Applies to covered <a href="#">plan</a> benefits only.</p>
If you are pregnant	Office visits	No charge	40% <a href="#">coinsurance</a>	<p>Applies to covered <a href="#">plan</a> benefits only.</p> <p>In some instances, services provided by an <a href="#">out-of-network provider</a> at an in-network facility may be payable at 20% <a href="#">coinsurance</a>.</p>
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services			

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Applies to covered <a href="#">plan</a> benefits only.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> (inpatient). 20% <a href="#">coinsurance</a> (outpatient).	40% <a href="#">coinsurance</a> (outpatient). Inpatient services not covered.	<a href="#">Preauthorization</a> is required for inpatient and speech therapy services (\$200 reduction in benefits if no <a href="#">preauthorization</a> ). Applies to covered <a href="#">plan</a> benefits only.
	<a href="#">Habilitation services</a>	Not covered	Not covered	You pay 100% of <a href="#">habilitation services</a> .
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required (\$200 reduction in benefits if no <a href="#">preauthorization</a> ). Applies to covered <a href="#">plan</a> benefits only. Maximum benefit is 70 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Replacement only if device is too worn for repair or change in physical condition rendering current device unusable.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Applies to covered <a href="#">plan</a> benefits only.
<b>If your child needs dental or eye care</b>	Children's eye exam	You pay for charges in excess of \$50 maximum calendar year benefit. No charge for <a href="#">preventive care</a> 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

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## 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.)

- Acupuncture services to a maximum of 20 visits per year
- Chiropractic 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](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 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 1-800-432-6636.]

[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.—————

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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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,570</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,620</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,570</b>