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 deductible? | $8,700 Individual/ $17,400 Family for In-Network.<br>$8,700 Individual / $17,400 Family for Out-of-Network.<br><br>Deductible is embedded. | 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. In-Network preventive care and services covered at "No charge". | 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? | $8,700 Individual/ $17,400 Family for In-Network.<br>$8,700 Individual/ $17,400 Family for In-Network.<br>Out-Of-Pocket Limit is embedded. | The out-of-pocket limit is the most you could pay in a year for coveredservices. 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? | Premiums, balance-billing charges, Pre-Certification penalties, 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 a network provider? | Yes. See for Cigna.com 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 orovider before you qet services. |
| Do you need a referral to see a soecialist? | No. | You can see the specialist you choose without a referral. |

**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 (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 | 0% after deductible | 0% after deductible | None |
| | Specialist visit | 0% after deductible | 0% after deductible | None |
| | Preventive care | 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 an will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% after deductible | 0% after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 0% after deductible | 0% after deductible | Pre-Certification is required on imaging. $500 penalty ap ies if not obtained. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.phoenixpbm.com | Generic drugs | 0% after deductible | Not covered | Prior authorization may be required on certain prescription drugs.<br><br>Benefits may vary if more than a 30-day supply is needed. |
| | Preferred brand drugs | 0% after deductible | Not covered | |
| | Non-preferred brand drugs | 0% after deductible | Not covered | |
| | Specialty drugs | 0% after deductible | Not covered | Specialty drugs with a gross cost of $700 are excluded from coverage unless approved through managed care. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% after deductible | Not covered | Pre-Certification required on surgical procedures. $500 penalty applies if not |

* 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 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Physician/surgeon fees | 0% after deductible | 0% after deductible | None |
| | Emergency room care | 0% after deductible | 0% after deductible | None |
| | Emergency medical transportation | 0% after deductible | 0% after deductible | None |
| | Urgent care | 0% after deductible | 0% after deductible | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% after deductible | 0% after deductible | Pre-Certification required. $500 penalty applies if not obtained. |
| | Physician/surgeon fees | 0% after deductible | 0% after deductible | None |
| If you need mental health, behavioral health,orsubstance abuse services | Outpatient services | 0% after deductible | Not covered | None. |
| | Inpatient services | 0% after deductible | Not covered | Pre-Certification is required on inpatient services. $500 penalty applies if not obtained. |
| If you are pregnant | Office visits | 0% after deductible | 0% after deductible | None |
| | Childbirth/delivery professional services | 0% after deductible | 0% after deductible | None |
| | Childbirth/delivery facility services | 0% after deductible | 0% after deductible | 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 | Home health care | 0% after deductible | 0% after deductible | Pre-Certification required. $500 penalty applies if not obtained. 60 visits/Calendar Year. |
| | Rehabilitation services | 0% after deductible | 0% after deductible | Physical, speech, occupational cardiac rehabilitation limited to 35 visits per Calendar Year, combined. |
| | Habilitation services | 0% after deductible | 0% after deductible | |
| | Skilled nursing care | 0% after deductible | 0% after deductible | Pre-Certification required. $500 penalty applies if not obtained. 25 days/ Calendar Year |

* 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 You will a the least | Out-of-Network Provider You will a the most | |
| 1t your child needs dental or eye care | Durable medical equipment | 0% after deductible | Not covered | Pre-Certification applies to DME, Orthotics, and Prosthetics. $500 penalty applies if not obtained. |
| | Hospice services | 0% after deductible | Not covered | Pre-Certification required for inpatient. $500 penalty applies if not obtained. 15 visits/days per lifetime. |
| | 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (25 visits per Plan Year)

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

**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. 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 your employer 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**

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 (Espanol): Para obtener asistencia en Espanol, llame al 1-855-699-5433.

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

Chinese (i=J=rX): P□*'$□i=J=rxs"J□il}J, iJH£tT3!1-%ii□ 1-855-699-5433.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-699-5433.

*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 document.

## 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 | $9,000 |
| Specialist coinsurance | 30% |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $9,000 |
| Copayments | $0 |
| Coinsurance | $900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$9,960** |

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

| | |
|---|---|
| The plan's overall deductible | $9,000 |
| Specialist coinsurance | 30% |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $5,420 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$5,440** |

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

| | |
|---|---|
| The plan's overall deductible | $9,000 |
| Specialist coinsurance | 30% |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

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

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

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

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