



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 ?	\$0 Individual / \$0 Family for In-Network. \$6,000/\$12,000 Out-of-Network.	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 ?	\$6,000 Individual / \$12,000 Family for In-Network. \$12,000/24,000 out of network	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 ?	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 Cigna PPO Network 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 ?	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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay , deductible does not apply	Deductible	None
	Specialist visit	\$50 copay , deductible does not apply	Deductible	None
	Preventive care/screening/immunization	No charge	Deductible	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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	Deductible	Labs performed during network office visit are included in office visit copay.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Deductible	Pre-Certification is required on imaging. \$500 penalty applies 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	Retail/Mail Order: \$0 copay /prescription, deductible does not apply	Not Covered	Prior authorization may be required on certain prescription drugs . Benefits may vary if more than a 30-day supply is needed.
	Preferred brand drugs	Retail: \$35 copay /prescription, deductible does not apply Mail Order: \$105 copay / prescription, deductible does not apply	Not covered	
	Non-preferred brand drugs	Retail: \$75 copay / prescription, deductible does not apply Mail Order: \$225 copay / prescription, deductible does not apply	Not covered	
	Specialty drugs	30% After deductible	Not covered	\$700 gross cost limit per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Deductible	Pre-Certification required on surgical procedures. \$500 penalty applies if not obtained.

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	
	Physician/surgeon fees	30% coinsurance after deductible	Deductible	None
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	Deductible	None
	Emergency medical transportation	No Charge	Deductible	None
	Urgent care	\$50 copay , deductible does not apply	Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Deductible	Pre-Certification required. \$500 penalty applies if not obtained.
	Physician/surgeon fees	30% coinsurance after deductible	Deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 copay , deductible does not apply Outpatient: 30% coinsurance after deductible	Deductible	None.
	Inpatient services	30% coinsurance after deductible	Deductible	Pre-Certification is required on inpatient services. \$500 penalty applies if not obtained.
If you are pregnant	Office visits	No Charge	Deductible	None
	Childbirth/delivery professional services	30% coinsurance after deductible	Deductible	None
	Childbirth/delivery facility services	30% coinsurance after deductible	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	30% coinsurance after deductible	Deductible	Pre-Certification required. \$500 penalty applies if not obtained. 60 visits/Calendar Year.
	Rehabilitation services	30% coinsurance after deductible	Deductible	Physical, speech, occupational cardiac rehabilitation limited to 35 visits per Calendar Year, combined.
	Habilitation services	30% coinsurance after deductible	Deductible	

* 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	
	Skilled nursing care	30% coinsurance after deductible	Deductible	Pre-Certification required. \$500 penalty applies if not obtained. 25 days/ Calendar Year.
	Durable medical equipment	30% coinsurance after deductible	Deductible	Pre-Certification applies to DME, Orthotics, and Prosthetics. \$500 penalty applies if not obtained.
	Hospice services	30% coinsurance after deductible	Deductible	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	Deductible	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 foot care - Weight loss programs - Routine eye care (Adult)
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. 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 (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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-699-5433.

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