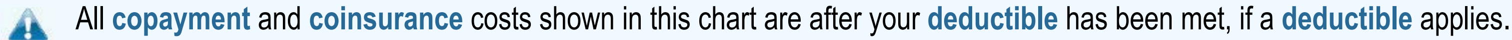
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit **http://mytotalrewards.prudential.com** or call **1-800-PRU-EASY (1-800-778-3279)**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider** or other **bolded** terms see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-800-PRU-EASY (1-800-778-3279)** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	***In-Network:*** **$1,500** for individual coverage / **$3,000** for family coverage (applies to in-network care only; does not apply to in-network **preventive care**). ***Out-of-Network:*** **$3,000** for individual coverage / **$6,000** for family coverage (applies to out-of-network care only).	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**, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network **preventive services** are 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 a list of covered **preventive services** at **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?	***In-Network:*** **$5,000** per individual / **$10,000** per family (includes the in-network **deductible** and **prescription drug** expenses; applies to in-network care only). ***Out-of-Network:*** **$10,000** per individual / **$20,000** per family (includes the out-of-network **deductible**; applies to out-of-network care only).	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-billed charges and health care charges this **plan** doesn't cover. Fertility **prescription drug** expenses do not apply to the **prescription drug out-of-pocket limit**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of participating **providers**, contact WebTPA at **www.prudential.webtpa.com** or call **1-800-230-5107**. The **plan** also includes access to networks, including Carrum Health, that provide certain eligible procedures at lower cost-sharing than other in-network providers. Contact WebTPA for more information.	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**.


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	Your Cost[1]		Limitations, Exceptions and Other Important Information[1]
		In-Network	Out-of-Network[2]	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **coinsurance**	40% **coinsurance**	***Cigna Tier 1 PCP:*** $20 **copay** per visit after in-network **deductible**
	Specialist visit	20% **coinsurance**	40% **coinsurance**	***Cigna Tier 1 Specialist:*** $40 **copay** per visit after in-network **deductible**
	Preventive care/**screening**/immunization	No charge	40% **coinsurance**	Subject to applicable age and frequency limits.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	——————none——————
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	Failure to obtain pre-certification for select services will result in no benefits being paid.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Generic drugs (non-specialty)	***Retail:*** 25% **coinsurance**, up to $25 maximum ***Home Delivery:*** 25% **coinsurance**, up to $62.50 maximum	Not covered	After **deductible**, your cost applies to up to a 30-day supply (retail); up to a 90-day supply (home delivery). No coverage for non-participating pharmacies. If you get a brand-name drug when a generic equivalent is available, you pay your regular share of the cost of the brand-name drug (your **deductible** or **coinsurance**, as applicable) as well as the difference in cost between the brand-name and generic. **Note:** This applies even if your physician requires the brand-name to be dispensed.
	Preferred brand drugs (non-specialty)	***Retail:*** 25% **coinsurance**, up to $50 maximum ***Home Delivery:*** 25% **coinsurance**, up to $125 maximum	Not covered	
	Non-preferred brand drugs (non-specialty)	***Retail:*** 40% **coinsurance**, up to $100 maximum ***Home Delivery:*** 40% **coinsurance**, up to $250 maximum	Not covered	

[1] For more details about your coverage and costs, you can obtain a copy of the Summary Plan Description (SPD) at **http://mytotalrewards.prudential.com** or by calling **1-800-PRU-EASY (1-800-778-3279)**.

[2] Amounts in excess of the Maximum Allowable Charge (MAC) are not covered for any common medical event.

Common Medical Event	Services You May Need	Your Cost[1]		Limitations, Exceptions and Other Important Information[1]
		In-Network	Out-of-Network[2]	
	Specialty drugs	*Home delivery only* ***Generic:*** You pay 25% coinsurance, up to $100 maximum ***Preferred Brand:*** You pay 40% coinsurance, up to $200 maximum	Not covered	Specialty drugs must be filled through OptumRx Specialty Services. Up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Failure to obtain pre-certification for select services will result in no benefits being paid.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	———————none———————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network is treated the same as in-network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to true emergency or medically necessary transportation.
	Urgent care	20% coinsurance	20% coinsurance	Out-of-network is treated the same as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Failure to obtain pre-certification for select services will result in no benefits being paid.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	———————none———————
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Failure to obtain pre-certification for select services will result in no benefits being paid.
	Inpatient services	20% coinsurance	40% coinsurance	———————none———————
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	———————none———————
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	———————none———————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Failure to obtain pre-certification for select services will result in no benefits being paid.

1 For more details about your coverage and costs, you can obtain a copy of the Summary Plan Description (SPD) at http://mytotalrewards.prudential.com or by calling **1-800-PRU-EASY (1-800-778-3279)**.

2 Amounts in excess of the Maximum Allowable Charge (MAC) are not covered for any common medical event.

Common Medical Event	Services You May Need	Your Cost[1] In-Network	Your Cost[1] Out-of-Network[2]	Limitations, Exceptions and Other Important Information[1]
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	40% **coinsurance**	——————none——————
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	——————none——————
	Habilitation services	Not covered	Not covered	None; not covered.
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Limited to 100 days per year (combined in- and out-of-network).
	Durable medical equipment	20% **coinsurance**	40% **coinsurance**	——————none——————
	Hospice services	20% **coinsurance**	40% **coinsurance**	——————none——————
If your child needs dental or eye care	Children's eye exam	No charge	40% **coinsurance**	Limited to eye exams provided by **primary care physician** as part of **preventive care** to age 18.
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	Not covered	Not covered	——————none——————

Excluded Services and 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.)

- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Custodial care
- Dental care (adult)
- Habilitative services
- Long-term care
- Routine eye care (adult)
- 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 (limitations apply)
- Bariatric surgery
- Chiropractic care (limitations apply)
- Hearing aids (limitations apply)
- Infertility treatment (Progyny network only; contact Progyny for details)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limitations apply)

[1] For more details about your coverage and costs, you can obtain a copy of the Summary Plan Description (SPD) at **http://mytotalrewards.prudential.com** or by calling **1-800-PRU-EASY (1-800-778-3279)**.

[2] Amounts in excess of the Maximum Allowable Charge (MAC) are not covered for any common medical event.

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: Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act**, or contact the Prudential HR Service Center at **1-800-PRU-EASY (1-800-778-3279)**. 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 on how 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: WebTPA at **1-800-230-5107**, or you may contact the Employee Benefits Security Administration at **1-866-444-3272** 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-PRU-EASY (1-800-778-3279)**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-PRU-EASY (1-800-778-3279)**.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-800-PRU-EASY (1-800-778-3279)**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-PRU-EASY (1-800-778-3279)**.

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

[1] For more details about your coverage and costs, you can obtain a copy of the Summary Plan Description (SPD) at **http://mytotalrewards.prudential.com** or by calling **1-800-PRU-EASY (1-800-778-3279)**.
[2] Amounts in excess of the Maximum Allowable Charge (MAC) are not covered for any common medical event.

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** **$1,500**
- **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	$1,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

- **The plan's overall deductible** **$1,500**
- **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	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

- **The plan's overall deductible** **$1,500**
- **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	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Note: Contributions you and Prudential (if applicable) make to the Bank of America HSA can be used to reduce the amount you pay toward eligible services.