**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 Preferred Benefit Administrators, Inc. 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.PreferredTPA.com or call 1-888-524-2777 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers:<br>$3,000 individual / $6,000 family<br>For out-of-network providers: Not covered | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care 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. |
| **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 network providers:<br>$4,000 individual / $8,000 family<br>For out-of-network providers: Not covered | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services 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 www.Cigna.com or call 1-888-524-2777 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. |

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 | Teladoc visit: $0 copay<br>PCP: $45 copay after deductible | Not covered | None |
| | Specialist visit | $75 copay after deductible | Not covered | None |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Blood work at freestanding lab: No charge after deductible.<br>X-ray at imaging center: $75 copay after deductible.<br>Blood work or X-ray at hospital: $200 copay after deductible. | Not covered | Preauthorization is required for imaging. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Imaging (CT/PET scans, MRIs) | $200 copay after deductible | Not covered | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.PreferredTPA.com | Generic drugs | $20 copay/prescription (retail)<br>$40 copay/prescription (mail order) | Not covered | Prescription copays apply after deductible has been met.<br>Retail / Pharmacy covers up to 30-day supply; Mail order Service covers 90-day supply.<br>Prescriptions from Out-of-network pharmacies are not covered. |
| | Brand drugs with no generic equivalent | $50 copay/prescription (retail)<br>$100 copay/prescription (mail order) | Not covered | |
| | Brand drugs with a generic equivalent | $75 copay/prescription (retail)<br>$150 copay/prescription (mail order) | Not covered | |
| | Specialty drugs | No charge after deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $300 copay after deductible | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Physician/surgeon fees | No charge after deductible | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | $500 copay after deductible | $500 copay after deductible | Emergency room copay waived if admitted to hospital.<br>Urgent care copays apply after deductible has been met. |
| | Emergency medical transportation | $75 copay after deductible | Not covered | |
| | Urgent care | PCP: $45 copay<br>Specialist: $75 copay | Not covered | |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | $250 copay per day after deductible. Maximum of 5 daily copays per confinement. | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Physician/surgeon fees | No charge after deductible | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45 copay after deductible | Not covered | Preauthorization is required for inpatient services. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Inpatient services | $250 copay per day after deductible. Maximum of 5 daily copays per confinement. | Not covered | |
| **If you are pregnant** | Office visits | $45 copay after deductible | Not covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge after deductible | Not covered | |
| | Childbirth/delivery facility services | $250 copay per day after deductible. Maximum of 5 daily copays per confinement. | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | $75 copay after deductible | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Rehabilitation services | $45 copay after deductible | Not covered | None |
| | Habilitation services | $45 copay after deductible | Not covered | |
| | Skilled nursing care | $250 copay per day after deductible. Maximum of 5 daily copays per confinement. | Not covered | Preauthorization is required. If you don't get preauthorization, benefits will be reduced by the lesser of $2,500 or 50%. |
| | Durable medical equipment | $75 copay after deductible | Not covered | |
| | Hospice services | $75 copay after deductible | Not covered | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | 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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Allergy Testing
- Chiropractic Care
- Orthotics / Prosthetics
- Private Duty Nursing
- Transplants

**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)4272 or 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 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 Preferred Benefit Administrators at 1-888-524-2777.

**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 1-888-524-2777

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-524-2777

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-524-2777

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-524-2777

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

## 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** **$3,000**
- **Physician copayment** **$45**
- **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 | $3,000 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,660** |

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

- **The plan's overall deductible** **$3,000**
- **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 | $3,000 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$4,260** |

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

- **The plan's overall deductible** **$3,000**
- **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 | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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