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: $3,000 individual / $6,000 family (reduced by $500 if MAP recommended provider is used) For out-of-network providers: No coverage	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. Preventive care, physician office visits, urgent care, outpatient mental health and alcohol & substance abuse treatment, laboratory, imaging & x-rays and prescription drugs 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 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?	For network providers: $7,000 individual / $14,000 family For out-of-network providers: No coverage	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, 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	$35 copay/office visit	No coverage	None
	Specialist visit	$35 copay/office visit	No coverage	None
	Preventive care/screening/ immunization	No charge	No coverage	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)	30% coinsurance	No coverage	None
	Imaging (CT/PET scans, MRIs)	At imaging center: $100 copay At hospital: 30% coinsurance	No coverage	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.PreferredTPA.com	Generic drugs (Tier 1)	$10 copay/prescription (retail) $30.00 copay/prescription (mail order)		Retail / Pharmacy covers up to 30-day supply; Mail order Service covers 90-day supply. Must use network pharmacy.
	Preferred brand drugs (Tier 2)	$40 copay/prescription (retail) $120.00 copay/prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	$80 copay/prescription (retail) $240.00 copay/prescription (mail order)		
	Specialty drugs (Tier 4)	$375 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	No coverage	Deductible may be reduced by $500 if MAP recommended provider is used.
	Physician/surgeon fees	30% coinsurance	No coverage	None
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible and $250 copay	30% coinsurance after network deductible and $250 copay	Emergency Room copay will be waived if admitted to the hospital.
	Emergency medical transportation	30% coinsurance	No coverage	
	Urgent care	$50 copay/visit	No coverage	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	No coverage	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	30% coinsurance	No coverage	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay / visit	No coverage	Preauthorization is required for inpatient admission. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	30% coinsurance	No coverage	
If you are pregnant	Office visits	$35 copay (initial visit)	No coverage	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	No coverage	
	Childbirth/delivery facility services	30% coinsurance	No coverage	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	No coverage	Maximum of 60 visits
	Rehabilitation services	30% coinsurance*	No coverage	*$35 copay for first 3 visits. Combined therapy maximum of 30 visits. Chiropractic care limited to 30 visits.
	Habilitation services	30% coinsurance*	No coverage	
	Skilled nursing care	30% coinsurance	No coverage	Maximum 100 visits/calendar year. Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $500.
	Durable medical equipment	30% coinsurance	No coverage	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	30% coinsurance	No coverage	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	None
	Children's glasses	No coverage	No coverage	None
	Children's dental check-up	No coverage	No coverage	None

* For more information about limitations and exceptions, see the plan or policy document at www.PreferredTPA.com

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.)		
• Cosmetic Surgery	• Long Term Care	• Routine eye care (Adult)
• Hearing Aids	• Non-emergency care when traveling outside the U.S.	• Routine Foot Care
• Infertility Treatment	• Private Duty Nursing	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric Surgery	• Orthotics / Prosthetics
• Allergy Testing	• Chiropractic Care	• 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
Specialist copayment	$35
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	$3,000
Copayments	$90
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$6,005**

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 copayment	$35
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	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$3,000
Specialist copayment	$35
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

Note: These numbers assume the patient does not participate in the plan's care coordination program through MAP. If you participate in the plan's care coordination program through MAP, you may be able to reduce your calendar year deductible up to $500. For more information about the care coordination program through MAP, please contact: Preferred Benefit Administrators, Inc. at 1-888-524-2777.

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