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, call 1-888-524-2777. 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: $1,350 individual / $2,700 family 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, prescription drugs, physician office visits, chiropractic care, emergency room, urgent care, outpatient (OP) alcohol & substance and OP mental health services, OP therapy & vision exams.	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 will have to meet the deductible before the plan pays for any services.
What is the out-of-pocket limit for this plan?	For network providers: $6,350 individual / $12,700 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, 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	$25 copay / vist	No coverage	None
	Specialist visit	$25 copay / visit	No coverage	None
	Preventive care/screening/ immunization	No cost	No coverage	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)	Freestanding Facility/Lab: No cost Physicians Office: $250 copay Outpatient Hospital: No cost after deductible	No coverage	None
	Imaging (CT/PET scans, MRIs)	Freestanding Imaging Facility: No cost Physicians Office: $1,500 copay Outpatient Hospital: No cost after deductible	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	$10 copay / prescription (retail) $0 copay / prescription (mail order)	No coverage	Retail / Pharmacy covers up to a 30-day supply; Mail order Service covers 90 day supply.
	Preferred Brand drugs	$30 copay / prescription (retail) $0 copay / prescription (mail order)	No coverage	
	Non-Preferred Brand drugs	$65 copay / prescription (retail) $0 copay / prescription (mail order)	No coverage	
	Specialty drugs	$300 copay / prescription	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: No cost Outpatient Hospital: No cost after deductible	No coverage	None
	Physician/surgeon fees	Ambulatory surgery center: No cost Outpatient Hospital: No cost after deductible	No coverage	

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 immediate medical attention	Emergency room care	True Emergency: $150 copay Non-Emergency: $500 copay	True Emergency: $150 copay Non-Emergency: No coverage	Emergency room copay waived if admitted to hospital.
	Emergency medical transportation	No cost after deductible	No coverage	
	Urgent care	$25 copay	No coverage	
If you have a hospital stay	Facility fee (e.g., hospital room)	No cost after deductible	No coverage	Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $500.
	Physician/surgeon fees	No cost after deductible	No coverage	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / visit	No coverage	Preauthorization is required for inpatient admission. If you don't get preauthorization, benefits will be reduced by $500.
	Inpatient services	No cost after deductible	No coverage	
If you are pregnant	Office visits	$25 copay (initial visit)	No coverage	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 cost	No coverage	
	Childbirth/delivery facility services	No cost after deductible	No coverage	
If you need help recovering or have other special health needs	Home health care	No cost after deductible	No coverage	Limited to 40 visits per year.
	Rehabilitation services	$25 copay / visit	No coverage	Physical, speech and occupational therapy limited to 12 visits per therapy type per year. Chiropractic limited to 6 visits per year.
	Habilitation services	$25 copay / visit	No coverage	
	Skilled nursing care	No cost after deductible	No coverage	Limited to 20 days. Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $500.
	Durable medical equipment	No cost after deductible	No coverage	Preauthorization is required for inpatient hospice care. If you don't get preauthorization, benefits will be reduced by $500.
	Hospice services	No cost after deductible	No coverage	

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 your child needs dental or eye care	Children's eye exam	$25 copay	No coverage	Age 6 and above; limited to one eye exam every two years; no glasses or lenses.
	Children's glasses	No coverage	No coverage	
	Children's dental check-up	No coverage	No coverage	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 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
- Routine eye care (Age 6+)
- 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 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**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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	$1,350
Physician copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

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

The plan's overall deductible	$1,350
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,260**

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

The plan's overall deductible	$1,350
Specialist copayment	$25
Hospital (facility) copay	$150
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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