




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](http://www.PreferredTPA.com) or call 1-888-524-2777 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> : \$3,000 individual / \$6,000 family For <a href="#">out-of-network providers</a> : \$3,000 individual / \$6,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , allergy visits, ambulance services, chiropractic care, emergency room, office visits, urgent care and prescription drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> : \$7,350 individual / \$14,700 family; For <a href="#">out-of-network providers</a> : No limit	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain preauthorization for services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.Cigna.com">www.Cigna.com</a> or call 1-888-524-2777 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Teladoc visit: \$0 <a href="#">copay</a> Primary care: \$30 <a href="#">copay</a>	Teladoc visit: \$0 <a href="#">copay</a> Primary care: \$30 + 20% <a href="#">copay</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a>	\$50 + 20% <a href="#">copay</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.PreferredTPA.com">www.PreferredTPA.com</a>	Generic drugs	\$10 <a href="#">copay</a> / per Rx (retail) \$20 <a href="#">copay</a> / per Rx (mail order)	No coverage	Retail & Specialty prescriptions: 30-day supply maximum; Mail Order prescriptions: 90-day supply maximum.
	Brand drugs with no generic equivalent	\$40 <a href="#">copay</a> / per Rx (retail) \$80 <a href="#">copay</a> / per Rx (mail order)	No coverage	
	Brand drugs with a generic equivalent	\$60 <a href="#">copay</a> / per Rx (retail) \$120 <a href="#">copay</a> / per Rx (mail order)	No coverage	
	<a href="#">Specialty drugs</a>	30% <a href="#">copay</a> / per Rx	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a>	\$250 <a href="#">copay</a>	Emergency room <a href="#">copay</a> waived if admitted to hospital.
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a>	\$100 + 20% <a href="#">copay</a>	
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a>	\$60 + 20% <a href="#">copay</a>	

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)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced by \$250 of allowable charge.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient admissions. If you don't get <a href="#">preauthorization</a> , benefits will be reduced by \$250 of allowable charge.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	Initial office visit: \$50 <a href="#">copay</a> All other visits: 20% <a href="#">coinsurance</a>	Initial office visit: \$50 <a href="#">copay</a> ; All other visits: 30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 20 visits each plan year.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> for chiropractic; All other therapy 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Chiropractic care limited to 35 visits each calendar year.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient admissions. If you don't get <a href="#">preauthorization</a> , benefits will be reduced by \$250 of allowable charge.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to one (1) annual exam
	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       | • Hearing Aids                                       | • Private Duty Nursing |
| • Bariatric Surgery | • Infertility Treatment                              | • Routine Foot Care    |
| • Cosmetic Surgery  | • Long Term Care                                     | • Weight Loss Programs |
| • Dental Care       | • Non-emergency care when traveling outside the U.S. |                        |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                     |                           |               |
|---------------------|---------------------------|---------------|
| • Allergy Testing   | • Orthotics / Prosthetics | • Transplants |
| • Chiropractic Care | • Routine eye care        |               |

**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](http://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](http://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, kwijigo holne' 1-888-524-2777

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

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.PreferredTPA.com](http://www.PreferredTPA.com)

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Physician copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$1,900

<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,010</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$25
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,785</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.