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: $4,000 individual / $8,000 family For out-of-network providers: $10,000 individual / $30,000 family	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. In-network preventive services and physician office visits are some of the services 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?	Yes. $300 individual / $300 family for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $6,000 individual / $12,000 family For out-of-network providers: $20,000 individual / $40,000 family	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. Visit www.Cigna.com or call Preferred Benefit Administrators at 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 **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 virtual visit: no cost PCP office visit: $30 copay	50% coinsurance after deductible	None
	Specialist visit	$55 copay	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No cost	50% coinsurance after deductible	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)	Independent Lab: No cost Hospital based Lab: $50 copay X-Rays/Diagnostic Tests: 30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for imaging. If you don't get preauthorization, benefits will be reduced by $750.
	Imaging (CT/PET scans, MRIs)	No cost if scheduled through Karias Health. 30% coinsurance after deductible if not scheduled through Karias Health.	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.PreferredTPA.com	Generic drugs	Retail: $10 copay Maintenance & Mail Order: $25 copay	Not covered	Prescription drug specific deductible of $300 per individual / $300 per family applies to all drugs except generic & preventive care drugs. Retail prescriptions: 30-day supply maximum. 90-day supply maximum for maintenance drugs. Mail Order prescriptions: 90-day supply maximum.
	Preferred Brand	Retail: $60 copay Maintenance & Mail Order: $150 copay	Not covered	
	Non-Preferred Brand	Retail: $100 copay Maintenance & Mail Order: $250 copay	Not covered	
	Specialty drugs	Generic: $25 copay Preferred: $150 copay Non-Preferred: $250 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $750.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	

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

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	30% coinsurance after deductible	Emergency: 30% coinsurance after In-Network deductible. Non-Emergency: 50% coinsurance after deductible.	None
	Emergency medical transportation	30% coinsurance after In-Network deductible		
	Urgent care	$60 copay	50% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits will be reduced by $750.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $30 copay Intensive outpatient treatment: No cost	50% coinsurance after deductible	Preauthorization is required for inpatient admissions. If you don't get preauthorization, benefits will be reduced by $750.
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	No cost	50% coinsurance after deductible	Maternity care may include tests and services described elsewhere in SBC. Preauthorization required for stays over 48 hours (normal delivery) or 96 hours (caesarean). If you don't get preauthorization, benefits will be reduced by $750.
	Childbirth/delivery professional services	No cost	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 20 visits.
	Rehabilitation services	Inpatient: 30% coinsurance after deductible Outpatient: $55 copay	50% coinsurance after deductible	Inpatient Rehab is limited to 60 days/yr (combined with Skilled Nursing facility). Preauthorization required for Inpatient Rehab. If you don't get preauthorization, benefits will be reduced by $750. Combined maximum of 25 visits/yr for Occupational, Physical & Speech therapy.

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)	
	Habilitation services	Early intervention: $30 copay * Developmental delay: $30 copay **	50% coinsurance after deductible	Covered when Medically Necessary to treat a mental health condition (i.e., autism). Limits do not apply to mental health conditions for Physical, Speech and Occupational therapies. *To age 3. **Preauthorization & visit limits based on services provided.
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Skilled nursing care limited to 60 days. Preauthorization is required for Skilled nursing, insulin pumps/supplies & equipment over $2,500 and Inpatient Hospice. If you don't get preauthorization, benefits will be reduced by $750.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	
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
- Dental Care (routine adult & child)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (adult & child)
- Private Duty Nursing
- 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.)

- Chiropractic Care (26 visits / yr)

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

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** **$4,000**
- **Specialist copayment** **$55**
- **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	$4,000
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,470**

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

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$55**
- **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	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- **The plan's overall deductible** **$4,000**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **30%**
- **Other copayment** **$55**

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	$2,100
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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