**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 1-800-495-5950. 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.pristx.com or call 1-800-495-5950 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$2,000** per Individual / **$6,000** per family for In-Network providers. **$4,000** per Individual / **$12,000** per Family for Out-of-Network providers. | 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 care and primary care services, or 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 a deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Medical: $5,000** per Individual / **$10,200** per Family for In-Network providers. **$10,000** per individual / **$30,000** per family for Out-of-Network.<br>**RX: $1,000** per Individual / **$3,000** per 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, 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 and select "Find A Doctor" 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. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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 | $20 copay/office visit, deductible does not apply | 30% coinsurance | None |
| | Specialist visit | $20 copay/ office visit, deductible does not apply | 30% coinsurance | None |
| | Preventive care/screening/ immunization | No charge. | 30% coinsurance | There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday. 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) | No charge | 30% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Preauthorization is required. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.pristx.com | Generic drugs (Tier 1) | Retail Participating: $20/prescription. Mail - $15/prescription; deductible does not apply. | $20% plus $20 copay | Limited to a 30-day supply at retail. Up to a 90-day supply through mail order. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 20% additional charge after the applicable copayment. Additional charge will not apply to any6 deductible |
| | Preferred brand drugs (Tier 2) | Retail Participating: $50/prescription. Mail - $40/prescription; deductible does not apply. | $20% plus $50 copay | |
| | Non-preferred brand drugs (Tier 3) | Retail Participating: $65/prescription. Mail - $55/prescription; deductible does not apply. | $20% plus $65 copay | |
| | Specialty drugs & Infusion Therapy (Tier 4) | Not covered | Not covered | Must be reviewed for medical necessity by case management. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate** | Emergency room care | $100 copay/visit plus 20% coinsurance; deductible | | If you are admitted to the hospital from emergency room, |

| 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) | |
| **medical attention** | | does not apply. | | inpatient benefits will apply. |
| | Emergency medical transportation | 20% coinsurance | | None. |
| | Urgent care | $45 copay/visit | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Precertification is required. Out of Network failure to precertify will result in a $250 reduction in benefits. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Intensive Outpatient/Partial Hospitalization | 20% coinsurance | 40% coinsurance | Requires Medical Review for Preauthorization. Failure to preauthorize will result in 50% reduction in benefits not to exceed $500. |
| | Inpatient services | 20% coinsurance at semiprivate room rate. | 40% coinsurance at semiprivate room rate. | Precertification is required. Out of Network failure to precertify will result in a $250 reduction in benefits. |
| | Psychological Testing | 20% coinsurance | 40% coinsurance | Requires Medical Review for Preauthorization. Out of Network failure to precertify will result in 50% reduction in benefits not to exceed $500. |
| **If you are pregnant** | Office visits | $20 copay/initial visit | 30% coinsurance | Cost Sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | 30% coinsurance | Preauthorization is required. Limited to 60 visits per Calendar Year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | For Outpatient, limited to combined 35 visits per year, including Chiropractic. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled Nursing Facility | No Charge | 30% coinsurance | Precertification is required. Out of Network failure to precertify will result in a $250 reduction in benefits. 25 day maximum per benefit period. Must immediately follow hospital stay. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Precertification is required. Out of Network failure to precertify will result in a $250 reduction in benefits. |
| | Hospice services | No Charge | 30% coinsurance | Preauthorization is required. |
| **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 |

[* For more information about limitations and exceptions, see the plan or policy document at www.pristx.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.)**

- Abortion
- Acupuncture
- Bariatric surgery
- Long-Term Care
- Cosmetic surgery
- Dental care (Adult)
- Private Duty Nursing
- Routine eye care (Adult – Except for routine eye exam only)
- 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
- Hearing aids
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your Plan Document.
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

**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: contact the Plan at 1-800-495-5950. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: The Plan at 1-800-495-5950; or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**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 1-800-495-5950.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-5950.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-495-5950.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-5950.

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



[* For more information about limitations and exceptions, see the plan or policy document at www.pristx.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 plan's overall deductible** | **$2000** |
| **Specialist *[cost sharing]*** | **$20** |
| **Hospital (facility) *[cost sharing]*** | **20%** |
| **Other *[cost sharing]*** | **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** | **$12,800** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $100 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,060** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2000** |
| **Specialist *[cost sharing]*** | **$20** |
| **Hospital (facility) *[cost sharing]*** | **20%** |
| **Other *[cost sharing]*** | **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** | **$7,400** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $10 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,670** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2000** |
| **Specialist *[cost sharing]*** | **$20** |
| **Hospital (facility) *[cost sharing]*** | **20%** |
| **Other *[cost sharing]*** | **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** | **$1,900** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $60 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,160** |

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