Tres Health Insurance Company: Prime $5,000 RBP **Coverage for: Employee & Family | Plan Type: PPO**

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 (888) 341-5606. 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.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000/Individual; $10,000/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 the 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, diagnostic services, and urgent care.	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?	**$9,100/Individual; $18,200/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. Contact (888) 341-5606 for assistance locating 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.

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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	**Encounter Fee:** $25 copay/visit.	40% coinsurance.	Limited to twelve (12) visits per calendar year. This benefit includes retail and walk-in clinics. Telemedicine is available for medical and mental health through MD Live and is not subject to the visit limits.
		All Other Services: $50 copay/visit.		
	Specialist visit	**Encounter Fee:** $50 copay/visit.	40% coinsurance.	Limited to twelve (12) visits per calendar year.
		All Other Services: $50 copay/visit.		
	Preventive care/screening/ immunization	No cost to Covered Person.	Not covered.	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)	**MedMo (radiology):** No cost to covered person.	40% coinsurance.	Non-hospital based services are limited to five (5) covered tests per calendar year. Hospital based lab services are limited to three (3) covered tests per calendar year. Hospital based radiology services are excluded.
		Outside MedMo (Non-Hospital Based Services): $50 copay/test.		
		Hospital Based Services (lab only): 30% coinsurance.		
	Imaging (CT/PET scans, MRIs)	**MedMo:** No cost to covered person.	40% coinsurance.	Limited to three (3) covered tests per calendar year. Preauthorization is required outside of Medmo.
		Outside MedMo (Non-Hospital Based Services): $350 copay/test.		

* For more information about limitations and exceptions, and how to obtain a copy of the plan or policy document contact (888) 341-5606.

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)	
		Hospital Based Services: Not covered.		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MyCigna.com.	Tier 1 drugs	**Retail:** $10 copay/drug. **Mail Order:** $30 copay/drug.	Not covered.	Preventive medications are covered at no cost to the Covered Person as required by applicable law. Retail is limited to a 30-day supply. Mail order is limited to a 90-day supply.
	Tier 2 drugs	**Retail:** $75 copay/drug. **Mail Order:** $225 copay/drug.	Not covered.	
	Tier 3 drugs	**Retail:** $150 copay/drug. **Mail Order:** $450 copay/drug.	Not covered.	
	Tier 4 drugs - Specialty drugs	Not covered.	Not covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Non-Hospital Based:** $350 copay/procedure.	**Non-Hospital Based:** 40% coinsurance.	Limited to two (2) non-hospital based surgeries and one (1) hospital based surgery per calendar year combined with other outpatient services. Preauthorization is required.
	Physician/surgeon fees	**Hospital Based:** 30% coinsurance.		
If you need immediate medical attention	Emergency room care	$750 copay/visit.		Limited to two (2) visits per calendar year.
	Emergency medical transportation	$500 copay/trip.		Limited to two (2) trips per calendar year. Only ground transport is covered.
	Urgent care	$75 copay/visit.	40% coinsurance.	Limited to three (3) visits per calendar year.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance.		Limited to ten (10) days per calendar year. Surgery is limited to two (2) procedures per calendar year. Preauthorization is required.

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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)	
	Physician/surgeon fees	30% coinsurance.		None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$350 copay/service.	40% coinsurance.	Limited to two (2) non-hospital based services and one (1) hospital based service per calendar year combined with other outpatient services
	Inpatient services	30% coinsurance.		Limited to ten (10) days per calendar year. Preauthorization is required.
If you are pregnant	Office visits	**Preventive Care:** No cost to Covered Person. **Primary Care:** $25 copay/visit. **Specialist:** $50 copay/visit.	40% coinsurance.	Primary care visits are limited to twelve (12) visits per calendar year. Specialist office visits are limited to twelve (12) visits per calendar year. Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance.		None.
	Childbirth/delivery facility services	30% coinsurance.		Limited to ten (10) days per calendar year. Preauthorization may be required.
If you need help recovering or have other special health needs	Home health care	$50 copay/visit.	Not covered.	Limited to twenty (20) visits per calendar year. Preauthorization is required.
	Rehabilitation services	$75 copay/visit.	Not covered.	Limited to twelve (12) visits **combined** per calendar year for physical, occupational and speech therapy. Preauthorization is required. ABA therapy and chiropractic care are limited to twelve (12) visits **each** per calendar year.

* For more information about limitations and exceptions, and how to obtain a copy of the plan or policy document contact (888) 341-5606.

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	Not covered.	Not covered.	None.
	Skilled nursing care	Not covered.	Not covered.	None.
	Durable medical equipment	**CPAP:** $400 copay/item. **Glucose Monitor:** $35 copay/item.	Not covered.	Coverage is only provided for CPAP machines and glucose monitors, and they must be obtained through ConnectDME.
	Hospice services	Not covered.	Not covered.	None.
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 (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine eye care (adult)
- 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

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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.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: (888) 341-5606 or the Department of Labor, Employee Benefits Security Administration at (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 (800) 318-2596.

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

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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	**$5,000**
Specialist copay	**$50**
Hospital (facility) coinsurance	**30%**
Other copay	**$50**

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	$5,000
Copayments	$260
Coinsurance	$1,820
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,140**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$5,000**
Specialist copay	**$50**
Hospital (facility) coinsurance	**30%**
Other copay	**$50**

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	$2,180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,200**

Mia's Simple Fracture

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

The plan's overall deductible	**$5,000**
Specialist copay	**$50**
Hospital (ER) copay	**$750**
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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$250
The total Mia would pay is	**$2,050**

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