This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.paragonbenefits.com or by calling 855-229-3060.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 person / $6,000 family Network providers, $6,000 person / $12,000 family non-Network providers. Doesn't apply to Network Preventive Care Services, prior authorization; cost containment penalties; and premiums don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart titled Common Medical Event for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $6,000 person / $12,000 family Network Providers, $12,000 person / $24,000 family non-Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, prior authorization and cost containment penalties, (balance-billed charges for non-Network providers) and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart titled Common Medical Event describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of Network Providers, see www.mycigna.com	If you use a Network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Beware; your Network **provider** may use an out-of-Network **provider** for some services. Plans use the term panel, in-network, preferred, or participating for **providers** in their **network**. See the chart titled Common Medical Event for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copay Per Visit	40% After Deductible	---------- none ----------
	Specialist visit	$60 Copay Per Visit	40% After Deductible	---------- none ----------
	Other practitioner office visit	20% After Deductible	40% After Deductible	---------- none ----------
	Preventive care / screening / immunization	No charge. Deductible does not apply	Not Covered	Preventive Care Services are not covered when provided by a Non-Network Provider. https://www.healthcare.gov/what-are-my-preventive-care-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	20% After Deductible	40% After Deductible	---------- none ----------
	Imaging (CT/PET scans, MRIs)	20% After Deductible	40% After Deductible	---------- none ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.partnersrx.com** **Or call:** **1-800-711-4550**	Generic drugs	Pharmacy: $10 copay per prescription. Up to 30 day supply Mail Order: $25 copay per prescription. Up to 90 day supply	Coverage for ingredient costs and dispensing fees only.	If employee chooses other than Generic when Generic is available, the employee is subject to the higher copay, drug price difference, and deductible.
	Preferred brand drugs	Pharmacy: $40 copay per prescription. Up to 30 day supply Mail Order: $100 copay per prescription. Up to 90 day supply	Coverage for ingredient costs and dispensing fees only.	
	Non-preferred brand drugs	Pharmacy: $70 copay per prescription. Up to 30 day supply Mail Order: $175 copay per prescription. Up to 90 day supply	Coverage for ingredient costs and dispensing fees only.	
	Specialty drugs	25% Copay ($300 max per prescription)	Coverage for ingredient costs and dispensing fees only.	Specialty Drugs available at Retail Pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% After Deductible (Hospital Charges) 100% after $250 copay per surgery (Free Standing Facility)	40% After Deductible	---------- none ----------
	Physician/surgeon fees	20% After Deductible	40% After Deductible	---------- none ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$300 Copay per Visit	$300 Copay per Visit	Copay waived if admitted.
	Emergency medical transportation	20% After Deductible	40% After Deductible	---------- none ----------
	Urgent care	$60 Copay per Visit	40% After Deductible	---------- none ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% After Deductible plus $500 Copay per admit The contracted rate	40% After Deductible	Prior authorization required.
	Physician/surgeon fee	20% After Deductible	40% After Deductible	---------- none ----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health Outpatient services	20% After Deductible	40% After Deductible	---------- none ----------
	Mental/Behavioral health Inpatient services	20% After Deductible Plus $500 Copay per admit The contracted rate	40% After Deductible	Prior authorization required.
	Substance use disorder Outpatient services	20% After Deductible	40% After Deductible	---------- none ----------
	Substance use disorder Inpatient services	20% After Deductible Plus $500 Copay per admit The contracted rate	40% After Deductible	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	20% After Deductible	40% After Deductible	Coverage for dependents other than spouse excluded.
	Delivery and all inpatient services	20% After Deductible	40% After Deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% After Deductible	40% After Deductible	---------- none ----------
	Rehabilitation services	Occupational Therapy **OR** Speech Therapy **OR** Physical Therapy 20% After Deductible	Occupational Therapy **OR** Speech Therapy **OR** Physical Therapy 40% After Deductible	Coverage limited to 60 days per Calendar Year maximum combined visits.
	Habilitation services	20% After Deductible	40% After Deductible	---------- none ----------
	Skilled nursing care	20% After Deductible the contracted rate	40% After Deductible	Coverage limited to 60 days per Calendar Year maximum.
	Durable medical equipment	20% After Deductible	40% After Deductible	---------- none ----------
	Hospice service	20% After Deductible	40% After Deductible	---------- none ----------
If your child needs dental or eye care	Eye exam	No charge	Not covered	As provided in Preventive Care services for children.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	No charge	Not covered	As provided in Preventive Care services for children.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical services
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs except in cases of morbid obesity

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private duty nursing
- Urgent Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the Plan Administrator at 855-229-3060. 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan administrator at 855-229-3060 or the plan's Claims administrator at 855-229-3060, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays:** $3542
- **Patient pays:** $3998

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3000
Copays	$90
Coinsurance	$908
Limits or exclusions	$0
Total	**$3998**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays:** $1260
- **Patient pays:** $4140

Sample care costs:

Prescriptions	$2900
Medical Equipment & Supplies	$1300
Office visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3000
Copays	$660
Coinsurance	$480
Limits or exclusions	$0
Total	**$4140**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.