V. Watts Furniture, Inc: Plan Option Plan 4

Coverage for: Individual/Family | Plan Type: Indemnity

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, visit us at <u>www.alliedbenefit.com</u> or call 1-888-306-0905. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> or call 1-888-306-0905 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$2,000 individual/\$4,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://</u> <u>www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ?	\$5,500 individual/\$11,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, penalty for not obtaining Preauthorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .
Will you pay less if you use a <u>participating provider</u> ?	Not applicable.	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit, then covered at 100%	<u>Copayment</u> is not subject to any <u>Deductible</u> . <u>Copay</u> applies to exam charge only. Does not include office surgery.
If you visit a health care <u>provider's</u> office	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, then covered at 100%	<u>Copayment</u> is not subject to any <u>Deductible</u> . <u>Copay</u> applies to exam charge only. See <u>Plan</u> Document for other services.
or clinic	Preventive care/ screening/ immunization	No charge. <u>Deductible</u> does not apply.	As required under the Affordable Care Act(ACA), <u>cost sharing</u> does not apply to identified clinical <u>preventive services</u> . Any other preventive medicine services covered under your <u>plan</u> are subject to <u>deductible</u> and <u>coinsurance</u> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information	
	Generic drugs (Tier 1)	\$20 <u>copay</u> retail/\$60 <u>copay</u> mail order	When the retail store offers a lower price for generic, pay only the lower price. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).	
If you need drugs to treat your illness or condition More information about	Preferred brand drugs (Tier 2)	\$50 <u>copay</u> retail/\$150 <u>copay</u> mail order	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).	
prescription drug coverage is available at www.myCigna.com	Non-preferred brand drugs (Tier 3)	\$75 <u>copay</u> retail/\$225 <u>copay</u> mail order	When a generic is available, pay the difference between the Brand and Generic contracted rate. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).	
<u>Specialty drugs</u> (⁻ 4)		30% <u>coinsurance</u>	To receive the <u>network provider</u> benefit, you must obtain <u>specialty drugs</u> from a specialty pharmacy <u>provider</u> as designated by us. Call 1-800-MyCigna for further information. <u>Specialty drugs</u> obtained from a non-designated specialty pharmacy <u>provider</u> will not be covered. Authorization is required. Benefits will not be paid for any <u>specialty drugs</u> that are not authorized by the Medical Review Manager.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be	
	Physician/surgeon fees	30% <u>coinsurance</u>	applied.	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information
lf you need	Emergency room care	30% <u>coinsurance</u>	Non-emergency use will result in a reduction of charges up to the <u>preauthorization</u> penalty amount. The penalty is not covered.
immediate medical attention	Emergency medical transportation	30% <u>coinsurance</u>	To the nearest Acute Medical Facility that can treat the sickness or injury.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, then covered at 100%	Copayment is not subject to any Deductible.
lf you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied.
	<u>Physician/surgeon</u> fees	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied.
If you need mental health, behavioral health, or substance	Outpatient services	\$40 <u>copay</u> /visit, then covered at 100%. 50% <u>coinsurance</u> for other services.	Limited to 40 visits per year. <u>Copayments</u> apply to the office visit charge only. Any other services covered under your <u>plan</u> are subject to <u>deductible</u> and <u>coinsurance</u> .
abuse services	Inpatient services	50% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied. Limited to 30 days per year.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information
lf you are pregnant	Office visits	\$60 <u>copay</u> /visit, then covered at 100%	<u>Copayment</u> is not subject to any <u>Deductible</u> . <u>Copay</u> applies to exam charge only. See <u>Plan</u> Document for other services.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	None
lf you need help	Home health care	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied. Limited to 60 visits per year.
recovering or have other special health needs	Rehabilitation services	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for Inpatient. If not received, a penalty will be applied. Inpatient limited to 31 days per year. Outpatient limited to 30 visits per year.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information
	Habilitation services	30% <u>coinsurance</u>	Preauthorization is required for Inpatient. If not received, a penalty will be applied. Inpatient limited to 31 days per year. Outpatient limited to 30 visits per year.
	Skilled nursing care	30% <u>coinsurance</u>	Preauthorization is required. If not received, a penalty will be applied.
	Durable medical equipment	30% <u>coinsurance</u>	Preauthorization is required for amounts greater than \$1,500. If not received, a penalty will be applied.
	Hospice services	30% <u>coinsurance</u>	None
	Children's eye exam	Not covered	None
lf your child needs dental or eye care	Children's glasses	Not covered	None
	Children's dental checkup	Not covered	None

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 surgeryDental care (Adult)
- Hearing aidsInfertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult), except for treatment of diabetes
- Routine foot care, except for treatment of diabetes
- 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: contact the plan at 1-888-306-0905 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the <u>plan</u> at 1-888-306-0905 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or <u>www.dol.gov/ebsa/healthreform</u>.

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 Standard? 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 1-888-306-0905. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-306-0905. Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-888-306-0905. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-306-0905.

To see examples of how this <u>plan</u> 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.

> \$2.000 \$60 30% 30%

Peg Is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Ma (a
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other coinsurance 	\$2,000 \$60 30% 30%	 The g Spec Hosp Othe

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	\$2,000
<u>Copayments</u>	\$10
Coinsurance	\$3,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,270

Managing Joe's type 2 Diabet (a year of routine in-network care of a we controlled condition)		
The plan's overall deductib	le \$2.0	
Specialist copayment	\$	
Hospital (facility) coinsurar	<mark>nce</mark> 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	\$900
Copayments	\$1,200
Coincurance	¢۵

The total Joe would pay is	\$2,120
Limits or exclusions	\$20
What isn't covered	
Coinsurance	\$U

Mia's Simple Fracture

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

The plan's overall deductible	\$2,000
Specialist copayment	\$60
Hospital (facility) <u>coinsurance</u>	30%
Other coinsurance	30%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic tests (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	

\$2,000
\$200
\$100
\$0
\$2,300

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