**Enhance Therapies-Silver Plan: American Plan Administrators** **Coverage for:** Individual, Individual + 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, contact 1-718-625-6300. 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.cciio.cms.gov or call 1-718-625-6300 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For participating providers $2,500 person / $5,000 family non-participating providers $10,000 person / $20,000 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. Preventive care and primary care services 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 deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| What is the out-of-pocket limit for this plan? | For participating providers $6,000 person/ $12,000 family non-participating providers $20,000 person / $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 (unless balance-billing is prohibited), 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 | 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 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 | $35 copay/office visit<br>deductible does not apply | 50% coinsurance | ----------None---------- |
| | Specialist visit | $60 copay/office visit<br>deductible does not apply | 50% coinsurance | ----------None---------- |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | 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) | No charge/office based<br>$150 copay/lab hospital<br>$300 copay/x-ray hospital<br>deductible does not apply | 50% coinsurance | |
| | Imaging (CT/PET scans, MRIs) | $100 copay/office based<br>$500 copay/hospital<br>deductible does not apply | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.proactrx.com | Generic drugs | $20 copay / Retail prescription<br>$40 copay / Mail Order | Not Covered | Covers up to a 3 retail 30 days fill (retail subscription); 90 day supply (mail order prescription). $100 surcharge applies for employee that continues to fill scripts that are covered by CanRx. |
| | Preferred brand drugs | $40 copay / Retail prescription<br>$80 copay / Mail Order | Not Covered | |
| | Non-preferred brand drugs | $60 copay / Retail prescription<br>$120 copay / Mail Order | Not Covered | |
| | Specialty drugs | Not Covered | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | |
| If you need immediate medical attention | Emergency room care | $450 copay<br>deductible does not apply | $450 copay<br>deductible does not apply | Copay Waived if admitted<br>Coverage is limited to Urgent Emergency Room visits only |
| | Emergency medical transportation | 25% coinsurance | 50% coinsurance | Coverage is limited to Emergency Ground Transportation only |
| | Urgent care | $75 copay<br>deductible does not apply | 50% coinsurance | ----------None---------- |
| If you have a hospital | Facility fee (e.g., hospital room) | 25% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get |

* For more information about limitations and exceptions, or to request the SPD contact us at 1-718-625-6300.

| 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) | |
| stay | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | preauthorization, services will not be covered.* |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $60 copay/ visit deductible does not apply | 50% coinsurance | ----------None---------- |
| | Inpatient services | 25% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| If you are pregnant | Office visits | $35 copay/ visit deductible does not apply | 50% coinsurance | ----------None---------- |
| | Childbirth/delivery professional services | 25% coinsurance | 50% coinsurance | ----------None---------- |
| | Childbirth/delivery facility services | 25% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| If you need help recovering or have other special health needs | Home health care | 25% coinsurance | 50% coinsurance | Coverage is limited to 40 days per year. Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| | Rehabilitation services | $60 copay/ visit deductible does not apply | 50% coinsurance | Coverage is limited to 30 combined visits per year |
| | Habilitation services | Not Covered | Not Covered | ----------None---------- |
| | Skilled nursing care | 25% coinsurance | 50% coinsurance | Coverage is limited to 60 days per year. Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| | Durable medical equipment | 25% coinsurance | 50% coinsurance | Preauthorization is required when the amount is > $500 |
| | Hospice services | 25% coinsurance | 50% coinsurance | Coverage is limited to 30 days per year Preauthorization is required. If you don't get preauthorization, services will not be covered.* |
| If your child needs dental or eye care | Children's eye exam | No Charge | 50% coinsurance | Coverage is limited to 1 exam per 24 months |
| | Children's glasses | No Charge | No Charge | Coverage is limited to $100 per 24 months |
| | Children's dental check-up | Not Covered | Not Covered | ----------None---------- |

* For more information about limitations and exceptions, or to request the SPD contact us at 1-718-625-6300.

## 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
- Habilitation Services
- Infertility treatment
- Long term care
- Medical Care when traveling outside the U.S.
- 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
- Eye Exam

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit www.dol.gov/ebsa/healthreform; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or visit www.cciio.cms.gov; or please call APA at 1-718-625-6300 or visit www.apatpa.com 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 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: APA at 1-718-625-6300 or visit www.apatpa.com.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
If you are in need of language assistance, please reference the multi-language taglines and nondiscrimination notification at the end of this document, or call us at 1-718-625-6300

*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, or to request the SPD contact us at 1-718-625-6300.

## 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 | $2,500 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

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 | $2,500 |
| Copayments | $340 |
| Coinsurance | $2,490 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $5,330 |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | 0$60 |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

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 | $2,500 |
| Copayments | $720 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Joe would pay is | $3,220 |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | 0$60 |
| Hospital (facility) copayment | $450 |
| Other coinsurance | 25% |

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 | $1,250 |
| Copayments | $1,050 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,300 |

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