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 GPA at 1-800-827-7223. 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 812-547-6427 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family PPO & Non-PPO	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Prescriptions & PPO preventive services do not apply towards the 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.
What is the out-of-pocket limit for this plan?	**Coinsurance Maximum: $2,000** person/ **$4,000** family Level I & Level II PPO & Non-PPO **Total Annual Maximum: $4,500** person/ **$9,000** family Level I & Level II PPO & Non-PPO (includes deductible & copayments)	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; 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.** Visit www.cigna.com or call 1-866-206-3224 for a list of participating 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.

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
		PPO Provider	Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance; deductible applies	50% coinsurance; deductible applies	There is no charge for PPO female office sterilization & all PPO FDA approved contraceptive methods. Chiropractic services are limited to 25 visits per calendar year. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Specialist visit	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Preventive care/screening/ immunization	No Charge	50% coinsurance; deductible applies	See your plan document for additional benefit information & limitations. Non-PPO charges are subject to Usual, Customary & Reasonable fees. 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)	20% coinsurance; deductible applies	30% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Copays: Retail $3/Mail Order $3		Covers a 30-90 day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded.
	Preferred brand drugs	Copays: Retail 20% up to $25 maximum Mail Order $25		
	Non-preferred brand drugs	Copays: Retail 30% up to $35 maximum Mail Order $35		
	Specialty drugs	Copays: $3 Generic 20% up to $25 maximum Preferred Brand 30% up to $35 maximum Non-Preferred Brand		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required if admitted inpatient or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual,

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
				Customary & Reasonable fees.
	Emergency medical transportation	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Urgent care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	UR notification required for inpatient admissions or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Inpatient services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you are pregnant	Office visits	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Contact UR for coordination of prenatal care. UR notification required or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Childbirth/delivery professional services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Childbirth/delivery facility services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	Services are limited per calendar year to 100 visits (max 4 hours per visits) for Home Health Care, 25 visits each for Physical/Occupational/Speech Therapy & 30 combined days for Skilled Nursing/ Rehabilitation Facilities. Treatment of developmental delays may not be covered. See your policy or plan document for additional information about **excluded services.** UR notification required for inpatient admissions, home health, outpatient hospice, DME & prosthetics or 50% benefit reduction non-compliance penalty applies. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Rehabilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Habilitation services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Skilled nursing care	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Durable medical equipment	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
	Hospice services	20% coinsurance; deductible applies	50% coinsurance; deductible applies	
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance; deductible applies	Benefit applies to routine vision screenings up to age 19. Non-PPO charges are subject to Usual,

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
				Customary & Reasonable fees.
	Children's glasses	Not Covered		Not Covered
	Children's dental check-up	Not Covered		Not Covered

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the 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.)

- Acupuncture
- Chiropractic Care
- Hearing Aids (**only** for initial purchase if hearing loss is due to illness, accidental injury, congenital anomaly or surgical procedure)

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: 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 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: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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.gpatpa.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	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$1,000
Copayments	$40
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,100**

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

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$1,000
Copayments	$440
Coinsurance	$380
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,880**

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

The plan's overall deductible	$1000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

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