The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and Cooper-Booth Wholesale Co. would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the Silver Medical Plan) 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) 488-4660. 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.mybenefits.maestrohealth.com or call (888) 488-4660 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,500 person / $5,000 family Out-of-network: $5,000 person / $10,000 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. **Deductible** starts over each plan year. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. See the chart starting on page 2 for how much you pay for covered services after you meet the **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 services even if you haven't yet met the deductible amount. But a copay 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?	$150 Rx Deductible $300 lifetime maximum deductible for all sterilization	You don't have to meet the deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Medical: $6,000 person/$12,000 family Rx $1,150 Person/$2,300 family Out-of-Network Medical: $12,000 person/$24,000 family. Rx: N/A	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-billed charges, penalties for failure to obtain preauthorization for services.	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 or call (888) 488-4660 for a list of 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 most if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge, what your plan pays (balance billing).
Do you need a referral to see a specialist?	No written referral or approval is required to see a **Specialist**.	You can see the **Specialist** you choose without permission from this plan.

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	$40 copay/visit deductible waived	50% after Deductible	None
	Specialist visit	$60 copay/visit deductible waived	50% after Deductible	None
	Preventive care/screening/ immunization	No Charge	50% after Deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	30% after deductible	50% after Deductible	None
	Imaging (CT/PET scans, MRIs)	30% after Deductible	50% after Deductible	None
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	$15 copay retail; $45 copay mail	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$45 copay retail; $135 copay mail	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	$65 copay retail; $195 copay mail	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	20% coinsurance up to a maximum of $600	Not Covered	Covers up to a 30-day supply (retail prescription or mail order prescription). Members must use Accredo Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after Deductible	50% after Deductible	Preauthorization is required.
	Physician/surgeon fees	30% after Deductible	50% after Deductible	None
If you need immediate medical attention	Emergency room care	$400 copay/visit deductible waived	$400 copay/visit deductible waived	Non-emergency use of the emergency room services is subject to $600 copay
	Emergency medical transportation	30% after Deductible	30% after Deductible	None
	Urgent care	$60 copay	$60 copay	All services including Lab & X-ray
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after Deductible	50% after Deductible	Preauthorization is required.
	Physician/surgeon fees	30% after Deductible	50% after Deductible	None

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

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit deductible waived	50% after Deductible	None
	Inpatient services	30% after Deductible	50% after Deductible	Preauthorization is required.
If you are pregnant	Office visits	No charge	50% after Deductible	None
	Childbirth/delivery professional services	30% after Deductible	50% after Deductible	None
	Childbirth/delivery facility services	30% after Deductible	50% after Deductible	None
If you need help recovering or have other special health needs	Home health care	30% after Deductible	50% after Deductible	None
	Rehabilitation services	30% after Deductible	50% after Deductible	Physical, speech and occupational therapy are limited to a combined maximum of 30 visits per plan year
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitative services
	Skilled nursing care	30% after Deductible	50% after Deductible	Preauthorization is required. Limited to a maximum of 100 days per plan year
	Durable medical equipment	30% after Deductible	50% after Deductible	None
	Hospice services	30% after Deductible	50% after Deductible	Preauthorization is required.
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

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

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)
- Weight Loss Programs
- Hearing Aids
- Long-term Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the United States
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Infertility Treatment

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: HHS, DOL, and/or other applicable agency contact information]. 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: **Maestro Health: PO Box 1178 Matthews, NC 28106**

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 888-488-4660.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-488-4660.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-488-4660.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-488-4660.]

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 mybenefits.maestrohealth.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	$2,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$6,671**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,280
Copayments	$0
Coinsurance	$3,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

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 copay	$60
Hospital (facility) coinsurance	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	**$4,002**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,360
Copayments	$1.490
Coinsurance	$558
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,463**

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

The plan's overall deductible	$2,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
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	**$286**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$970
Copayments	$180
Coinsurance	$490
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,639**

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