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 your Unified Claims Account Manager at 1-800-291-5837 or see www.UnifiedGrp.com. 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 your Human Resources Department at Somerset Wood Products, Inc. at 1-606-561-4146 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | Single / Family: $1,500 / $3,000 In-Network; $3,000 / $6,000 Out-of-Network | 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, Physician office visits, Emergency Room visits, Urgent Care visit, and Prescription Drugs 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. |
| What is the out-of-pocket limit for this plan? | Single / Family: $5,000 / $10,000 In-Network; $10,000 / $20,000 Out-of-Network. Includes Deductible. Prescription drug copayments combined with the above In Network Out-of-Pocket limits cannot exceed $7,900 single/$15,800 family as required by the Affordable Care Act. | 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, balanced billed charges, services this plan doesn't cover, and preauthorization penalties. | 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. For a list of preferred providers, see Cigna at www.Cigna.com or call 1-800-291-5837. | 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 | $30 Copay | Deductible, 40% | Copay includes the office visit charge, lab services, in-office surgery and allergy serum. All other services are subject to Deductible/Coinsurance. |
| | Specialist visit | $60 Copay | Deductible, 40% | Copay includes the office visit charge, in-office surgery and allergy serum. All other services are subject to Deductible/Coinsurance. |
| | Preventive care/screening/ immunization | No Charge | Deductible, 40% | As required by the Affordable Care Act. Deductible and coinsurance do not apply In-Network. |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductible, 20% | Deductible, 40% | Select independent labs are payable at 100% by the plan. |
| | Imaging (CT/PET scans, MRIs) | Deductible, 20% | Deductible, 40% | None |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.true-rx.com. | Generic drugs | 30-day supply- $10 Copay<br>90-day supply- $20 Copay | | Retail pharmacy- 30-90 day supply<br>Mail Order- 90 day supply<br><br>Prescription drugs obtained at an Out-of-Network Pharmacy must be submitted to the Pharmacy Network for reimbursement of the discounted drug less the appropriate copay. |
| | Preferred brand drugs | 30-day supply- $50 Copay<br>90-day supply- $120 Copay | | |
| | Non-preferred brand drugs | 30-day supply- $75 Copay<br>90-day supply- $180 Copay | | |
| | Specialty drugs | 1st fill only-<br>25% up to $500 maximum | | After the 1st fill, specialty drugs at the pharmacy are not covered. Some specialty drugs may be covered under the Medical Portion of this plan. |

| 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 have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductible, 20% | Deductible, 40% | None |
| | Physician/surgeon fees | Deductible, 20% | Deductible, 40% | None |
| If you need immediate medical attention | Emergency room care | $300 Copay, then 20% | | Deductible does not apply. Copay waived upon admittance. |
| | Emergency medical transportation | In-Network Deductible, 20% | | None |
| | Urgent care | $30 Copay | Deductible, 40% | Copay includes the office visit charge, lab services and in-office surgery. All other services are subject to Deductible/Coinsurance. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Deductible, 20% | Deductible, 40% | Precertification required, failure will result in a $250 reduction in benefits. |
| | Physician/surgeon fees | Deductible, 20% | Deductible, 40% | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $30 Copay | Deductible, 40% | Copay includes the office visit charge only. All other services are subject to Deductible/Coinsurance. |
| | Inpatient services | Deductible, 20% | Deductible, 40% | Precertification required, failure will result in a $250 reduction in benefits. |
| If you are pregnant | Office visits | Same as any other Illness or as required by the Affordable Care Act. | | Coverage for all covered females. |
| | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | | | |

| 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 help recovering or have other special health needs | Home health care | Deductible, 20% | Deductible, 40% | Limited to 100 visits per calendar year. |
| | Rehabilitation services | Deductible, 20% | Deductible, 40% | Inpatient rehabilitation is limited to 60 days per Calendar Year and requires precertification. Physical, Occupational and Speech therapy are limited to 20 visits each. Home or office visits are subject to the applicable office visit copay. |
| | Habilitation services | Not Covered | | None |
| | Skilled nursing care | Deductible, 20% | Deductible, 40% | Precertification required, failure will result in a $250 reduction in benefits. Limited to 90 days per calendar year. |
| | Durable medical equipment | Deductible, 20% | Deductible, 40% | None |
| | Hospice services | Deductible, 20% | Deductible, 40% | With six (6) month life expectancy. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Deductible, 40% | Limited to visual acuity prevention by a Primary Care Physician for children through age 5. |
| | Children's glasses | Not Covered | | None |
| | Children's dental check-up | No Charge | Deductible, 40% | Limited to dental caries prevention by a Primary Care Physician for preschool age children. |

## 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<br>• Bariatric surgery<br>• Cosmetic surgery (unless stated otherwise in the plan document) | • Dental care (adult)<br>• Infertility treatment<br>• Hearing Aids<br>• Long-term Care | • Routine Eye Care (adult)<br>• 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 (limited to 12 visits per calendar year) | • Non-emergency care when traveling outside the U.S. (Unless the covered person traveled to that location to receive services, supplies and/or treatment.) | • Private-duty Nursing<br>• Routine foot care (Only when medically necessary for the treatment of a metabolic or peripheral-vascular disease.) |

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: your Human Resources Department at Somerset Wood Products, Inc. at 1-606-561-4146, 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: Unified Group Services Appeal Department at 1-800-291-5837.

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 1-800-291-5837
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-5837
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-291-5837
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-291-5837

*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.UnifiedGrp.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 | $1,500 |
| Specialist copayment | $60 |
| 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 | $1,500 |
| Copayments | $40 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| The total Peg would pay is | $3,250 |

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $60 |
| 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 | $300 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| The total Joe would pay is | $1,130 |

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

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $60 |
| 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 | $1,200 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,700 |

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