**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, visit www.smw36benefits.org 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 https://www.healthcare.gov/sbc-glossary or call (314) 652-8175 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500** member/spouse<br>**$300** dependent child<br>**$1,300** family maximum | 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 is covered before you meet your deductible. The deductible applies to all services, unless otherwise noted in the chart starting on page 2. | 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 care without cost sharing and before you meet your deductible. See a list of covered preventive care 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?** | **Medical: $4,000** person/ **$8,000** family<br>**Prescription: $2,850** person/**$5,700** 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 limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Vision and dental services, premiums, balance-billing charges, 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.mycigna.com or call (314) 652-8175 for a list of network providers. | This plan uses a provider network. You pay the least 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 | Network Provider | Out-of-Network Provider | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | Not Covered | ———none——— |
| | Specialist visit | 20% coinsurance | Not Covered | ———none——— |
| | Preventive care/screening/immunization | No Charge | Not Covered | ———none——— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | Prior authorization is required for select services. |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available www.smw36benefits.org | Generic drugs | $10 copayment 30-day supply<br>$25 copayment 90-day supply<br>Deductible does not apply | Not Covered | AmWINS Rx is the Pharmacy Network. Covers up to a 90-day supply (retail or mail order prescription) after the first two fills. |
| | Preferred brand drugs | $50 copayment 30-day supply<br>$125 copayment 90-day supply<br>Deductible does not apply | Not Covered | |
| | Non-preferred brand drugs | 50% copayment 30-day supply<br>50% copayment 90-day supply<br>Deductible does not apply | Not Covered | |
| | Specialty drugs | If you obtain specialty drugs through Reliance Rx and there is copay assistance, you pay $0. If you obtain specialty drugs from Reliance Rx and there is not copay assistance, you are responsible for 25% coinsurance up to the pharmacy out-of-pocket limit of $2,850 per year. | | Specialty drugs must be filled through the Fund's exclusive Specialty Pharmacy, Reliance Rx. Prior authorization required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not Covered | Prior authorization required for select services. |
| | Physician/surgeon fees | 20% coinsurance | Not Covered | Prior authorization required for select services. |
| **If you need immediate medical attention** | Emergency room care | $115 copayment<br>20% coinsurance | $115 copayment<br>20% coinsurance | ———none——— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ———none——— |

| Common Medical Event | Services You May Need | Network Provider | Out-of-Network Provider | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | Urgent care | 20% coinsurance | Not Covered | ———none——— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not Covered | Prior authorization required. |
| | Physician/surgeon fee | 20% coinsurance | Not Covered | Prior authorization required. |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | 20% coinsurance | Not Covered | Prior authorization required for select services. |
| | Inpatient services | 20% coinsurance | Not Covered | Prior authorization required for select services. |
| **If you are pregnant** | Office visits | No Charge | Not Covered | Pregnancy related charges are not covered for dependent children. |
| | Childbirth/delivery professional services | 20% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 20% coinsurance | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Prior authorization required. Limited to 40 visits per year. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Prior authorization required. |
| | Habilitation services | Not Covered | Not Covered | No coverage |
| | Skilled nursing care | 20% coinsurance | Not Covered | Prior authorization required. |
| | Durable medical equipment | 20% coinsurance | Not Covered | Prior authorization required for select services. |
| | Hospice services | 20% coinsurance | Not Covered | Prior authorization required. Limited to 26 weeks. |

| Common Medical Event | Services You May Need | Network Provider | Out-of-Network Provider | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| **If your *child* needs dental or eye care** | Children's eye exam | Coverage is limited to $60 and one exam/year | | |
| | Children's glasses | Coverage is limited to $150 for frames and up to $120 for lenses for one pair of glasses **or** up to $230 for a 12-month supply of contacts/year | | |
| | Children's dental check-up | No Charge | 20% coinsurance Deductible does not apply | Delta Dental of Missouri is the dental provider network. |

## 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
- Chiropractic Care
- Cosmetic Surgery
- Habilitation Services
- Infertility Treatment
- Hearing Aids
- Non-Emergency Care when traveling outside the U.S.
- Long-Term Care
- 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.)**

- Routine Dental Care (Adult)
- Routine Vision Care (Adult)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or http://www.dol.gov/agencies/ebsa. 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 the Benefit Office at (314) 652-8175 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or visit http://www.dol.gov/agencies/ebsa.

**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 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 (314) 652-8175
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (314) 652-8175
Vietnamese (CHÚ Ý): để nhận được hỗ trợ trong tiếng Tây Ban Nha, xin vui lòng gọi đến các (314) 652-8175
Serbo-Croatian (OBAVJEŠTENJE): Za pomoć na hrvatskom, nazovite (314) 652-8175

***To see examples of how this plan 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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$0**
- **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 | $200 |
| Copayments | $80 |
| Coinsurance | $2,460 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,960** |

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$0**
- **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 | $500 |
| Copayments | $0 |
| Coinsurance | $1,380 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **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** **$500**
- **Emergency room copayment** **$115**
- **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 | $500 |
| Copayments | $115 |
| Coinsurance | $257 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$872** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Benefit Office at (314) 652-8175

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