



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 \$300 dependent child \$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 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 More information about prescription drug coverage is available www.smw36benefits.org | Generic drugs | \$10 copayment 30-day supply \$25 copayment 90-day supply 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 \$125 copayment 90-day supply Deductible does not apply | Not Covered | |
| | Non-preferred brand drugs | 50% copayment 30-day supply 50% copayment 90-day supply Deductible does not apply | Not Covered | GLP-1 drugs prescribed for weight loss have a \$200 copay for a 30-day supply. |
| | 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 20% 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. |

| Common Medical Event | Services You May Need | Network Provider | Out-of-Network Provider | Limitations, Exceptions & Other Important Information |
|--|--|--|--|---|
| If you need immediate medical attention | Emergency room care | \$115 copayment 20% coinsurance | \$115 copayment 20% coinsurance | ——none—— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——none—— |
| | 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. |

| Common Medical Event | Services You May Need | Network Provider | Out-of-Network Provider | Limitations, Exceptions & Other Important Information |
|--|----------------------------------|---|--|--|
| | Hospice services | 20% coinsurance | Not Covered | Prior authorization required. Limited to 26 weeks. |
| If your <i>child</i> 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 .) | | |
|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Chiropractic Care • Cosmetic Surgery • Habilitation Services | <ul style="list-style-type: none"> • Infertility Treatment • Hearing Aids • Non-Emergency Care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.) | | |
| <ul style="list-style-type: none"> • Routine Dental Care (Adult) | | <ul style="list-style-type: none"> • 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 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$10 |
| Coinsurance | \$2,410 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,980 |

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 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$780 |
| Coinsurance | \$290 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,590 |

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$120 |
| Coinsurance | \$440 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,060 |

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