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, [insert contact information]. 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 receive a copy of the Glossary by calling the Welfare Fund office at: 516-741-5564 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network **$3,000**/Individual; $6,000/family Out-of-network **$6,000**/Individual; $12,000/family	Generally, you must pay 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. Physician urgent care visits, and prescription drugs.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,150/Individual; $16,300 family, in-network. Out-of-network Unlimited.	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.
What is not included in the out-of-pocket limit?	Copayments, 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 (646) 381-8851 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 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 you 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.	This plan will pay some or all of the costs to see a specialist for covered services.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	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	$40 copay: deductible does not apply.	40% coinsurance	None
	Specialist visit	$60 copay/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	None. **Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs.**
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Pre-certification required. **Not covered at a Hospital unless the test cannot be performed at a diagnostic center or participating labs.**
If you need drugs to treat your illness or condition For information visit www.empirxhealth.com or call (877) 241-7123	Generic drugs	$0 copay retail/$0 mail.	Not covered	Covers up to 34-day supply retail. 90-day supply mail order maximum. Retail claims - EmpiRx: (877) 241-7123 Mail order claims: (877) 241-7123
	Preferred brand drugs	25% coinsurance.	Not covered	
	Non-preferred brand drugs	50% coinsurance.	Not covered	
	Specialty drugs	Not covered	Not covered	Specialty drugs are available through Payer Matrix only at 1-877-305-6202.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Pre-certification required.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Pre-certification required.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	No coverage for Air Transport
	Urgent care	$40 copay: deductible does not apply.	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Pre-certification required. Limited to 120 days.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	Pre-certification required.

[* For more information about limitations and exceptions, see the SPD.]

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	40% coinsurance	None
	Inpatient services	30% coinsurance	40% coinsurance	Pre-certification required. Limited to 120 days.
If you are pregnant	Office visits	$40 copay	40% coinsurance	
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	Normal delivery/48 hours. Cesarean section/96 hours. Pre-certification is required.
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	Pre-certification required. Limited to 120 days.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Pre-certification required.
	Rehabilitation services	30% coinsurance	40% coinsurance	Outpatient: limited to 30 visits per calendar year. Inpatient limited to 120 days per calendar year. Pre-certification is required.
	Habilitation services	30% coinsurance	40% coinsurance	
	Skilled nursing care	30% coinsurance	40% coinsurance	Pre-certification required. Limited to 120 days.
	Durable medical equipment	30% coinsurance	40% coinsurance	Shoe inserts are covered for up to a maximum payment of $500 every 2 years.
	Hospice services	30% coinsurance	40% coinsurance	Maximum of six months and three bereavement counseling sessions. Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	In-network only up to Plan maximum.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	In-network only up to Plan maximum.

[* For more information about limitations and exceptions, see the SPD.]

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 • Cochlear implants • Cosmetic surgery • Infertility treatment • Acupuncture • Dependent Pregnancy	• Long-term care • No coverage outside the U.S. • Private-duty nursing • Transplants • Initial $25,000 in medical charges resulting from a motor vehicle accident not covered	• Routine foot care • Weight loss programs • Hearing aids • Dental care (adults) • Routine eye care (adults) • Pain Management

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care, up to 30 visits per year.	• Routine eye care exam, (dependent child only)	• Routine dental checkup (dependent child only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can call the plan at: 516-741-5564. You may also contact the Department of Labor's Employee Benefits Security Administration at: 1-866-444-EBSA or www.dol.gov/ebsa/healthreform. 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 SPD provides 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 Welfare Fund at 516-741-5564.

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 516-741-5564.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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** **$3,000**
- **Specialist *[cost sharing]*** **$60**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **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	**$8,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$60
Coinsurance	$1,452
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$4,612**

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

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$60**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **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	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,450**

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

- **The plan's overall deductible** **$3,000**
- **Specialist *[cost sharing]*** **$60**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **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	**$3,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$180
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,310**

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