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.theamericanworker.com or call 1-855-495-1192. 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 1-855-495-1192 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,000** per person / **$12,000** per family for Network Providers; **$10,000** per person / **$20,000** per family for Out-of-Network Providers.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes**	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?	**$6,000** per person / **$12,000** per family for Network Providers; **$11,000** per person / **$22,000** per family for Out-of-Network Providers.	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 billing charges, amounts over UCR, cost containment penalties and excluded 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.mycigna.com or call 1-855-495-1192 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 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	**No**	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Specialist visit	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Preventive care/screening/ immunization	No Charge	10% coinsurance after deductible is met	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible is met	10% coinsurance after deductible is met	COVID testing is covered at 100% when medically appropriate.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible is met	10% coinsurance after deductible is met	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling CerpassRx at 844-636-7506 or visiting www.CerpassRx.com	Generic drugs	No Charge after deductible is met	Not Covered	Retail: up to a 31-day supply; Mail Order: up to a 90-day supply. You may need to obtain certain specialty drugs through a pharmacy designated by CerpassRx. Certain drugs may have a pre-authorization requirement. Generic contraceptives are covered at No Charge. Not all drugs are covered.
	Preferred brand drugs	No Charge after deductible is met	Not Covered	
	Non-preferred brand drugs	No Charge after deductible is met	Not Covered	
	Specialty drugs	No Charge after deductible is met	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible is met	10% coinsurance after deductible is met	Preauthorization is required for procedures that have the potential to be cosmetic in order to avoid a 25% benefit reduction.
	Physician/surgeon fees	No Charge after deductible is met	10% coinsurance after deductible is met	Preauthorization is required for procedures that have the potential to be cosmetic in order to avoid a 25% benefit reduction.
If you need immediate medical attention	Emergency room care	No Charge after deductible is met	No Charge after in-network deductible is met	---None---
	Emergency medical transportation	No Charge after deductible is met	No Charge after in-network deductible is met	---None---
	Urgent care	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible is met	10% coinsurance after deductible is met	Preauthorization is required in order to avoid a 25% benefit reduction.
	Physician/surgeon fees	No Charge after deductible is met	10% coinsurance after deductible is met	Preauthorization is required in order to avoid a 25% benefit reduction.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Inpatient services	No Charge after deductible is met	10% coinsurance after deductible is met	Preauthorization is required in order to avoid a 25% benefit reduction.
If you are pregnant	Office visits	No Charge after deductible is met	10% coinsurance after deductible is met	Cost sharing does not apply for preventive services. Inpatient services must be preauthorized for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay in order to avoid a 25% benefit reduction.
	Childbirth/delivery professional services	No Charge after deductible is met	10% coinsurance after deductible is met	
	Childbirth/delivery facility services	No Charge after deductible is met	10% coinsurance after deductible is met	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible is met	10% coinsurance after deductible is met	Limited to 90 visits per calendar year. Services must be preauthorized in order to avoid a 25% benefit reduction.
	Rehabilitation services	No Charge after deductible is met	10% coinsurance after deductible is met	Limited to 20 visits per calendar year for Physical, Speech, Occupational, Pulmonary

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)	
				and Cognitive therapy. Limited to 36 visits per calendar year for Cardiac therapy.
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	No Charge after deductible is met	10% coinsurance after deductible is met	Services must be preauthorized in order to avoid a 25% benefit reduction. Limited to 60 days per calendar year.
	Durable medical equipment	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
	Hospice services	No Charge after deductible is met	10% coinsurance after deductible is met	---None---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

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)
- Dental care (Child)
- Eye care (Child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic (limited to 20 visits per CYM)

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 (3272) 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 documents also

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

provide complete information on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 855-495-1192.

*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.theamericanworker.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	**$0**
Specialist *[cost sharing]*	**100%**
Hospital (facility) *[cost sharing]*	**100%**
Other *[cost sharing]*	**100%**

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	$6,000
Copayments	$0
Coinsurance	$0
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	**$0**
Specialist *[cost sharing]*	**100%**
Hospital (facility) *[cost sharing]*	**100%**
Other *[cost sharing]*	**100%**

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	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**100%**
Hospital (facility) *[cost sharing]*	**100%**
Other *[cost sharing]*	**100%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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