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. If you want more detail about your coverage and costs, check your Summary Plan Description, visit our website at www.iambtf.org, call Cigna HealthCare at 1-800-Cigna24 (1-800-244-6224), or contact the Fund Office at 1-800-317-7594. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For in-network providers & out-of-network providers: **$400**/individual or **$1,200**/family	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. In-network preventive care & immunizations, 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?	For in-network providers **$4,400**/individual or **$9,200**/family For out-of-network providers **$8,400**/individual or **$17,200**/family On prescription drug coverage **$2,000**/individual or **$4,000**/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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for 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.

Important Questions	Answers	Why This Matters
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** 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 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 In-network provider (You will pay the least)	 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	20% coinsurance/visit	40% coinsurance	None
	Specialist visit	20% coinsurance/visit	40% coinsurance	Podiatry care limited to 30 visits/calendar year
	Preventive care/ screening/ immunization **Deductible does not apply	No charge/visit** No charge/screening** No charge/immunizations**	40% coinsurance/visit** 40% coinsurance/screening** 40% coinsurance/ immunizations** **Deductible does not apply	Various age and frequency limits Various age and frequency limits Various age and frequency limits You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required

Common Medical Event	Services You May Need	What You Will Pay In-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 drugs to treat your illness or condition Call CVS/Caremark at 1-800-282-8503 for info about Mail-Order and about what needs preauthorization .	Generic drugs (Tier 1; No copay for contraceptives)	$20 copay for 34-day supply $40 copay for 90-day supply	$20 copay for 34-day supply	34-day supply can be obtained from all retail pharmacies.
	Preferred drugs (Tier 2)	$40 copay for 34-day supply $80 copay for 90-day supply	$40 copay for 34-day supply	90-day supply is available only for maintenance drugs obtained from Mail-Order or at CVS pharmacies.
	Non-preferred drugs (Tier 3)	$50 copay for 34-day supply $100 copay for 90-day supply	$50 copay for 34-day supply	Preauthorization required for many medications.
	Specialty drugs (Tier 4)	$40 copay for generic $80 copay for preferred $100 copay for non-preferred	Not covered	Preauthorization and specialty pharmacy use is required for all specialty drugs. Call CVS Caremark at 1-800-237-2767 for information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance (40% if not a true emergency)	None
	Emergency medical transportation	20% coinsurance	20% coinsurance (40% if not a true emergency)	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required

Common Medical Event	Services You May Need	What You Will Pay In-network provider (You will pay the least)	 Out-of-network provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay In-network provider (You will pay the least)	 Out-of-network provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage of a home health aide as part of an approved treatment program is limited to 40 visits per year. Other limitations apply and preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization required. Coverage is limited to annual max of 50 days of combined rehabilitation services.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required. Admission must be within 7 days of a 5-day or more acute inpatient stay. Coverage is limited to 50% of prior acute care hospital's average semi-private room rate (or negotiated rate) and is limited to 100 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required. Rental limited to purchase price
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/outpatient services	40% coinsurance/inpatient; 40% coinsurance/outpatient services	Limitations apply and preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture (for pain only)
- Bariatric Surgery (in-network Centers of Excellence only)
- Chiropractic care (20 days)
- Emergency care when traveling outside the U.S.

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 provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800- Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: DC Office of the Health Care Ombudsman and Bill of Rights at 877-685-6391. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

---------- 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	$400
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	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$400
Copayments	$20
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,830**

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

The plan's overall deductible	$400
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	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$400
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,900**

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

The plan's overall deductible	$400
Specialist coinsurance	20%
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	$400
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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

NATIONAL IAM
BENEFIT TRUST FUND

ADDITIONAL INFORMATION FOR PARTICIPANTS

Statement of Nondiscrimination

The National IAM Benefit Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.

Proficiency of Language Assistance Services

English: ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-457-3481.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-3481.

繁體中文 **(Chinese):** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-800-457-3481。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-3481.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-457-3481 번으로 전화해 주십시오.

Tagalog (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-3481.

Русский **(Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-3481.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-3481. (**Arabic**)

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-3481.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-800-457-3481.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-3481.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-3481.

日本語 **(Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-457-3481 まで、お電話にてご連絡ください。

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-3481.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-3481.

Farsi (Persian): **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس 1-800-457-3481 بگیرید.