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, go to www.bridgedeck.org/health-benefit-forms/ or call 1-877-667-5522 or 410-850-8500. 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 www.healthcare.gov/sbc-glossary/ or by calling 1-877-667-5522 or 410- 850-8500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 Individual/$500 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and 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.
Are there other deductibles for specific services?	Yes. $150 for a non-network primary care provider visit and $150 for an inpatient admission. There are no other specific deductibles.	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?	$3,000 Individual/$10,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, charges in excess of the allowable amount (balance billing charges), non-covered services/health care this plan does not cover, deductibles, and penalties for failure to obtain precertification for 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. For a list of network providers, see www.bridgedeck.org/wp-content/uploads/2023/03/Health-and-Benefit-Provider-List.pdf or call Cigna at 1-800-768- 4695 or MultiPlan at 1-800-464-0292	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. 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.

Important Questions	Answers	Why This Matters:
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		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	$15 copay/visit	10% coinsurance after $150 non-network deductible	None
	Specialist visit	$25 copay/visit Acupuncture & Chiropractic: 10% coinsurance	30% coinsurance	Acupuncture and chiropractic care combined limited to 30 visits per calendar year and/or $2,100.
	Preventive care/screening/ immunization	No charge first $1,250/family, deductible does not apply; then 10% coinsurance	No charge first $1,250/family, deductible does not apply; then 30% coinsurance	Subject to age and frequency schedule. The following are not subject to any deductible or copay, and are not part of the $1,250 limit: colorectal cancer screening using sigmoidoscopy or colonoscopy starting at age 50 until 75 once every 5 years, a mammogram for women over age 40 every year, and cervical cancer screening every three years.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Must be recommended by physician.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic drugs	Retail - 20% coinsurance, minimum $7.50 copay per prescription fill or	Retail Only - 20% coinsurance, minimum $7.50 copay per prescription fill or refill	Deductible does not apply.

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)	
coverage is available at www.[insert].com		refill; Mail Order - 20% coinsurance, maximum $75 copay per prescription fill or refill	plus difference in cost between participating and non-participating pharmacy	Covers up to a 30-day supply plus 2 refills (retail prescription); 31-60-day supply (mail order prescription). Mandatory mail order after 2 refills. Controlled substance limited to 30 days. No non-participating pharmacy benefits available for mail order. If a generic equivalent of a brand name drug is available, and you or your eligible dependent(s) request the brand name version, you will be responsible for paying the difference in cost between the brand name drug and the generic equivalent, in addition to the minimum copay amounts.
	Brand drugs without Generic Equivalent	Retail - 20% coinsurance, minimum $15 copay per prescription fill or refill; Mail Order - 20% coinsurance, maximum $75 copay per prescription fill or refill	Retail Only - 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy	
	Brand drugs with Generic Equivalent	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus cost between generic and brand name drug	Retail Only - 20% coinsurance, minimum $15 copay per prescription fill or refill plus cost between generic and brand and difference in cost between participating and non-participating pharmacy	
	Specialty drugs	Subject to applicable coinsurance/copay above	Subject to applicable coinsurance/copay above	Deductible does not apply. Requires precertification from Caremark CVS.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance
	Physician/surgeon fees	Physician/surgeon fees	10% coinsurance	30% coinsurance; Multiple surgeries – 50% coinsurance for 2nd surgery and 75% coinsurance thereafter

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 need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	Balances over plan allowance	Balances over plan allowance	Emergency only. Transport to nearest facility. Air ambulance limited to maximum of $10,000 per instance.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/admission then 10% coinsurance	$150/admission then 30% coinsurance	$250 reduction for 1st failure to precertify and 50% for subsequent claims. Maximum $400,000/transplant; maximum for bone marrow allogenic $870,000/transplant maximum for kidney $300,000/transplant. Donor expenses up to $10,000 OAP only.
	Physician/surgeon fees	10% coinsurance and 5% for transplant	30% coinsurance; Multiple surgeries - 50% coinsurance for 2nd and 75% coinsurance thereafter	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: 10% coinsurance up to maximum $15 copay/visit Substance abuse office visits: 10% coinsurance up to maximum $15 copay/visit Other outpatient: 10% coinsurance	30% coinsurance	None
	Inpatient services	$150 deductible/admission then 10% coinsurance	$150 deductible/admission then 30% coinsurance	$250 reduction for 1st failure to precertify and 50% for subsequent claims.
If you are pregnant	Office visits	$15 copay/PCP visit, $25 copay/specialist visit	10% coinsurance/PCP, 30% coinsurance/specialist	None
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None

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)	
	Childbirth/delivery facility services	$150/admission then 10% coinsurance	$150/admission then 10% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Covers up to 30 days/year for RN, LPN or LVN. Must follow hospital stay or outpatient procedure.
	Rehabilitation services	10% coinsurance	30% coinsurance	60 visits/days/year, inpatient and outpatient combined following hospital stay or outpatient procedure for heart disease or stroke; all other, 90 visits/days/year combined inpatient and outpatient.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	10% coinsurance	30% coinsurance	$250 reduction for 1st failure to pre-certify and 50% for subsequent claims. Outpatient nursing care must follow hospital stay or outpatient procedure.
	Durable medical equipment	10% coinsurance	30% coinsurance	Pre-determination required. Any purchase is property of plan.
	Hospice services	10% coinsurance	30% coinsurance	Bereavement not covered. Out-of-network hospice services covered only if there is no network facility or provider within 30 miles of the individual's primary caregiver's residence.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	One exam/year for children under age 19.
	Children's glasses	No charge up to plan allowance	No charge up to plan allowance	Plan allowance of $280 for a pair of glasses or $200/contacts every two years. Benefits provided through EyeMed, contact 866-299-1358.
	Children's dental check-up	20% coinsurance	30% coinsurance	One exam/6 months. Benefits provided through Delta Dental, contact 800-932-0783.

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 (unless necessary due to accident or breast reconstruction)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (acupuncture and chiropractic care combined limited to 30 visits per calendar year and/or $2,100)
- Bariatric surgery (if medically necessary to treat morbid obesity)
- Chiropractic care (chiropractic care and acupuncture combined limited to 30 visits per calendar year and/or $2,100)
- Dental care (Adult) ($2,000 annual maximum for periodontal; $3,000 lifetime orthodontic)
- Hearing aids (Exam - $75 maximum; Hearing Aids: For adults, $3,000 maximum once every 36 months; for individuals under 19, payable as medically necessary once in each 12-month period.)
- Infertility treatment and family building benefits (covered through Progyny's network providers with member paying 30% coinsurance with no deductible and out-of-pocket maximum not applicable)
- Private-duty nursing (when provided by RN, LPN, LVN or nursing assistant in hospital)
- Routine eye care (Adult) (once every 2 years, non-contracted providers limited to $540)
- Routine foot care

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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: the MM&P Plan Office at 700 Maritime Boulevard, Suite A, Linthicum Heights, MD 21090-1996; Phone: 410-850-8500; Toll-free: 1-877-667- 5522. You may also contact the Department of Labor's Employees 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 (410)-850-8500/1-(877)-667-5522.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (410)-850-8500/1-(877)-667-5522.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (410)-850-8500/1-(877)-667-5522.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (410)-850-8500/1-(877)-667-5522.

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	**$250**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other *[cost sharing]*	**10%**

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	$400
Copayments	$180
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,790**

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

The plan's overall deductible	**$250**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$250
Copayments	$200
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,630**

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

The plan's overall deductible	**$250**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$250
Copayments	$100
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.