



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, call (202) 636-8181 or toll-free (800) 983-2699. 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 1-800-983-2699 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible? | For in-network providers \$100 individual/\$200 family For out-of-network providers \$700 individual/\$1,400 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. Wellness benefits, hearing aids, and mental health/substance abuse benefits 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Medical: For in-network providers \$400 individual/\$800 family Medical: For out-of-network providers \$4,000 individual/\$8,000 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? | Deductible , copayments , penalties, 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.cignasharedadministration.com or call 1-800-768-4695 for a list of in-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 | | Limitations, Exceptions, & Other Important Information* |
|--|--|--|---|---|
| | | In-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 | 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/immunization | <p>No charge for doctor visits for routine physical exam and tests</p> <p>No charge for flu shots or COVID-19 vaccine</p> <p>No charge for Immunizations* for children under age 4</p> <p>10% coinsurance, deductible waived, for immunizations* for adults and children age 4 and older</p> | <p>No charge for doctor visits for routine physical exam and tests</p> <p>No charge for flu shots or COVID-19 vaccines</p> <p>No charge for Immunizations* for children up to age 3</p> | <p>You may have to pay for services that aren't preventive that are received during the same doctor's visit. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</p> <p>The following preventive care benefits are provided at no charge both in- and out-of-network:</p> <ul style="list-style-type: none"> • Pap test – females age 18 and older - once every two years • BRCA1 and BRCA2 tests – as recommended by the US Preventive Services Task Force • Mammogram for females age 40 and older – once/year • Proctology screening for males: <ul style="list-style-type: none"> ○ Age 40 to 49 – once every other year ○ Age 50 and older – once/year • Routine colonoscopies starting at age 45 – once every 10 years, but 3 years after a Cologuard test. Cologuard colon cancer screening test age 45 to 85 – once every 3 years; but after 5 years from a routine colonoscopy. |

*For more information about limitations and exceptions, see the plan or policy document by calling 1-800-983-2699. Covered expenses are limited to the Allowable Charge. Out-of-network benefits and Allowable Charges apply even if your in-network provider refers you to an out-of-network provider. Balance billing doesn't **2 of 8** apply for out-of-network emergency room care or treatment from an ancillary provider at certain in-network facilities.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|---|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | *Immunizations are those recommended by the Advisory Committee on Immunization Practices. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Preauthorization required for certain genetic tests. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com/local639 . | Generic drugs | Retail - \$5 copay /prescription Mail - \$5 copay /prescription | Not covered | Retail: Up to a 30-day supply Mail: Up to a 90-day supply For a brand drug with a generic drug available, you pay a \$5 copay plus the cost difference between the generic and brand. |
| | Preferred brand drugs | Retail - \$20 copay /prescription Mail - \$30 copay /prescription | Not covered | Preauthorization required for certain prescription drugs. If you don't get preauthorization , benefits could be reduced where plan pays nothing. Quantity Limits apply for certain drugs. Step therapy and specialty guideline management applies for certain drugs. Specialty drugs are provided through CVS/Caremark's specialty pharmacy. |
| | Non-preferred brand drugs | Retail - \$35 copay /prescription Mail - \$50 copay /prescription | Not covered | Maintenance Drugs are only covered up to three fills from a retail network pharmacy. Must obtain through mail order service after third fill. |
| | Specialty drugs | No charge | Not covered | Seasonal influenza vaccines including COVID-19 vaccine and non-seasonal vaccines (Shingles and Pneumonia) covered at participating pharmacies at no charge. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|---|--|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | Diabetic supplies, insulin pumps and glucose monitors are covered in full with a \$0 copay. Preauthorization with Cigna also required for certain medical out-patient injectable medications. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Preauthorization required for all non-emergency ambulatory and outpatient surgeries. If you don't get preauthorization , benefits could be reduced where plan pays 80% of the benefits payable. Out-of-network ancillary services at in-network facility: 20% coinsurance |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$100 copay /visit, 20% coinsurance | \$100 copay/visit, 20% coinsurance | Copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 40% coinsurance | Out-of-network air ambulance: 20% coinsurance |
| | 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 prior to hospital admission. In an emergency or life-threatening situation, notify Cigna within 24 hours of admission. If you don't get preauthorization , benefits could be reduced where plan pays 80% of the benefits payable for non-certified hospital expenses. In-patient physician fees limited to one visit/day. Out-of-network ancillary services at in-network facility: 20% coinsurance . Services provided at an out-of-network facility due to an emergency admission through the emergency room will be paid by the plan at 80% (20% coinsurance paid by you) until you are stable enough to be transferred to an in-network facility. If you choose to remain at the out-of-network facility after being stabilized, |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* |
|--|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | post-stabilization services will be paid by the plan at the out-of-network rate of 60% (40% coinsurance paid by you). |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Mental/behavioral health - 10% coinsurance , deductible waived Substance abuse – No charge | Mental/behavioral health - 30% coinsurance , deductible waived Substance abuse – 40% coinsurance , deductible waived | None |
| | Inpatient services | Mental/behavioral health - 10% coinsurance , deductible waived Substance abuse – No charge | Mental/behavioral health - 30% coinsurance , deductible waived Substance abuse – 40% coinsurance , deductible waived | Preauthorization required prior to hospital admission. If you don't get preauthorization , mental/behavioral health and substance abuse in-network benefits could be reduced where plan pays 70% coinsurance and substance abuse out-of-network benefits could be reduced where plan pays 80% of the benefits payable for non-certified hospital expenses. Out-of-network ancillary services at in-network facility: 10% coinsurance Mental/behavioral health; No charge Substance abuse |
| If you are pregnant | Office visits | | | Preauthorization required prior to hospital admission. In an emergency or life-threatening situation, notify Cigna within 24 hours of admission. If you don't get preauthorization , benefits could be reduced where plan pays 80% of the benefits payable for non-certified hospital expenses. Depending on the type of services, coinsurance , or deductible may apply. Dependent children's pregnancies are not covered. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | | | |
| If you need help recovering or have | Home health care | 20% coinsurance | 40% coinsurance | None |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information* | |
|---|---|--|---|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | | |
| other special health needs | Rehabilitation services | 20% coinsurance | 40% coinsurance | Preauthorization required after eight Physiotherapy or Chiropractic visits and before Speech, Occupational and Vision Therapy is provided. Services may not be covered if you don't get preauthorization . \$1,000 maximum benefit for chiropractic care per year. | |
| | Habilitation services | | | | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | | None |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | | Rental charges paid up to the purchase price. Purchase charges covered if lower than rental. |
| | Hospice services | 20% coinsurance | 40% coinsurance | | Preauthorization required prior to admission. If you don't get preauthorization , benefits could be reduced where plan pays 80% of the benefits payable. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Plan reimburses up to \$30 | Coverage limited to one exam/year | |
| | Children's glasses | No Charge. Frame allowance \$150 | Plan reimburses per a schedule | Coverage limited to one pair of lenses/year, frames every other year | |
| | Children's dental check-up | No Charge | Not covered | Coverage limited to two visits/year | |

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"> • Bariatric surgery • Cosmetic surgery • Certain prescriptions • Infertility treatment | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the US • 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"> • Acupuncture • Chiropractic care | <ul style="list-style-type: none"> • Dental care (Adult) • Hearing Aids | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) |

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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 (866) 444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>. 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 Fund Office at 1-800-983-2699 or Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) <https://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: (800) 983-2699.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: (800) 983-2699.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码: (800) 983-2699.

[Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’: (800) 983-2699.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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](#) \$100
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other coinsurance](#) 20%
- [Other \(Rx\) copayments](#) \$5

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 | \$100 |
| Copayments | \$15 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$585 |

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [Other \(Rx\) copayments](#) \$5/\$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 | \$100 |
| Copayments | \$170 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$230 |
| The total Joe would pay is | \$700 |

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist coinsurance](#) 20%
- [Hospital \(facility\) copayments](#) \$100
- [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 | \$100 |
| Copayments | \$100 |
| Coinsurance | \$345 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$545 |