



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 <a href="#">deductible</a> ?	For <a href="#">in-network providers</a> \$100 individual/\$200 family For <a href="#">out-of-network providers</a> \$700 individual/\$1,400 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Wellness benefits, hearing aids, and mental health/substance abuse benefits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> \$400 individual/\$800 family For <a href="#">out-of-network providers</a> \$4,000 individual/\$8,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Deductible</a> , <a href="#">copayments</a> , <a href="#">penalties</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.cignasharedadministration.com">www.cignasharedadministration.com</a> or call 1-800-768-4695 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Preventive care/screening/immunization</a>	<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% <a href="#">coinsurance</a>, <a href="#">deductible</a> waived, for immunizations for adults and children age 4 and older</p>	<p>No charge for Doctor visits and tests</p> <p>No charge for immunizations for children up to age 3 and flu shots for all</p>	<p>You may have to pay for services that aren't <a href="#">preventive</a>. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.</p> <p>Immunizations are those recommended by the Advisory Committee on Immunization Practices.</p> <p>Pap test – females age 18 and older - once every two years</p> <p>BRCA1 and BRCA2 tests – as recommended by the US Preventive Services Task Force</p> <p>Mammogram for females: Age 40 and older – once/year</p> <p>Proctology screening for males: Age 40 to 49 – once every other year Age 50 and older – once/year</p> <p>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.</p>

\*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)	
If you have a test	Diagnostic test (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None except that preauthorization required for certain genetic tests.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com/local639">www.caremark.com/local639</a> .	Generic drugs	Retail - \$5 <a href="#">copay</a> /prescription Mail - \$5 <a href="#">copay</a> /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 <a href="#">copay</a> plus the cost difference between the generic and brand.
	Preferred brand drugs	Retail - \$20 <a href="#">copay</a> /prescription Mail - \$30 <a href="#">copay</a> /prescription	Not covered	<a href="#">Preauthorization</a> required for certain prescription drugs. If you don't get <a href="#">preauthorization</a> , benefits could be reduced where <a href="#">plan</a> pays nothing.
	Non-preferred brand drugs	Retail - \$35 <a href="#">copay</a> /prescription Mail - \$50 <a href="#">copay</a> /prescription	Not covered	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.
	Specialty drugs	No charge	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.  Seasonal influenza vaccines including COVID-19 vaccine and non-seasonal vaccines (Shingles and Pneumonia) covered at participating pharmacies at no charge.
				<a href="#">Preauthorization</a> with Cigna also required for certain medical out-patient injectable medications.

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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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for all non-emergency ambulatory and outpatient surgeries. If you don't get <a href="#">preauthorization</a> , benefits could be reduced where <a href="#">plan</a> pays 80% of the benefits payable. Out-of-network ancillary services at in-network facility: 20% coinsurance
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit, 20% <a href="#">coinsurance</a>	\$100 copay/visit, 20% coinsurance	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Out-of-network air ambulance: 20% coinsurance
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required prior to hospital admission. In an emergency or life-threatening situation, notify Cigna within 24 hours of admission. If you don't get <a href="#">preauthorization</a> , benefits could be reduced where <a href="#">plan</a> 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, post-stabilization services will be paid by the plan at the out-of-network rate of 60% (40% coinsurance paid by you).
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Mental/behavioral health - 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived Substance abuse – No charge	Mental/behavioral health - 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived Substance abuse – 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived	None
	Inpatient services	Mental/behavioral health - 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived Substance abuse – No charge	Mental/behavioral health - 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived Substance abuse – 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> waived	<a href="#">Preauthorization</a> required prior to hospital admission. If you don't get <a href="#">preauthorization</a> , mental/behavioral health and substance abuse <a href="#">in-network</a> benefits could be reduced where <a href="#">plan</a> pays 70% <a href="#">coinsurance</a> and substance abuse <a href="#">out-of-network</a> benefits could be reduced where <a href="#">plan</a> 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
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required prior to hospital admission. In an emergency or life-threatening situation, notify Cigna within 24 hours of admission. If you don't get <a href="#">preauthorization</a> , benefits could be reduced where <a href="#">plan</a> pays 80% of the benefits payable for non-certified hospital expenses. Depending on the type of services, <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Dependent Children's pregnancies are not covered.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
<b>If you need help recovering or have</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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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	<u>Habilitation services</u>			<u>Preauthorization</u> 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 <u>preauthorization</u> . \$1,000 maximum benefit for chiropractic care per year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Rental charges paid up to the purchase price. Purchase charges covered if lower than rental.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required prior to admission. If you don't get <u>preauthorization</u> , benefits could be reduced where <u>plan</u> 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.)

- Acupuncture
- Infertility treatment
- Routine foot care
- Bariatric surgery
- Long-term care
- Non-emergency care when traveling outside the US
- Cosmetic surgery
- Certain prescriptions
- Weight loss programs

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

- Chiropractic care
- Private-duty nursing
- Dental care (Adult)
- Routine eye care (Adult)
- Hearing Aids

**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

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<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](http://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>. \*\*The Fund does not have a grievance procedure. All disputes under the Plan are processed through the appeals procedure described in the Summary Plan Description.

#### 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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' [insert telephone number].]

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*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 <a href="#">plan's overall deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ <a href="#">Other coinsurance</a>	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** **\$12,700**

**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$100
Copayments	
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$585</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's overall deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ <a href="#">Hospital (facility) coinsurance</a>	20%
■ <a href="#">Other (Rx) copayments</a>	\$5

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	\$415
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$415
<b>The total Joe would pay is</b>	<b>\$1,330</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's overall deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ <a href="#">Hospital (facility) copayments</a>	\$100
■ <a href="#">Other coinsurance</a>	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
<b>The total Mia would pay is</b>	<b>\$545</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.