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?	For in-network providers $400 individual/$800 family 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	No charge for doctor visits for routine physical exam and tests
		
		No charge for flu shots or COVID-19 vaccine
		
		No charge for Immunizations* for children under age 4
		
		10% coinsurance, deductible waived, for immunizations* for adults and children age 4 and older
			No charge for doctor visits for routine physical exam and tests
			
			No charge for flu shots or COVID-19 vaccines
			
			No charge for Immunizations* for children up to age 3
				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.
				
				The following preventive care benefits are provided at no charge both in- and out-of-network:
				• 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:
				  ○ 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.
				
				*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.

*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 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)	
	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. 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. 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. Preauthorization with Cigna also required for certain medical out-patient injectable medications.
	Preferred brand drugs	Retail - $20 copay/prescription Mail - $30 copay/prescription	Not covered	
	Non-preferred brand drugs	Retail - $35 copay/prescription Mail - $50 copay/prescription	Not covered	
	Specialty drugs	No charge	Not covered	

*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 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 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, 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% coinsurance	40% coinsurance	

*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 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 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	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. Depending on the type of services, coinsurance, or deductible may apply. Dependent children's pregnancies are not covered.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	

*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 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)	
	Habilitation services			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.
	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.)

- Bariatric surgery
- Cosmetic surgery
- Certain prescriptions
- Infertility treatment
- 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.)

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

*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 apply for out-of-network emergency room care or treatment from an ancillary provider at certain in-network facilities.

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, kwiijigo 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	$360
Coinsurance	$400
What isn't covered	
Limits or exclusions	$415
The total Joe would pay is	**$1,275**

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**

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