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, visit www.8thdistrictbenefits.org or call 844-989-2321. 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 844-989-2321 to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network, Out-of-Network* and Out-of-Area combined: $400 per person / $1,200 per family per calendar year. **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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. Outpatient Prescription Medicines and in-network preventive 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. For example, this plan covers certain in-network 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?	Yes. Dental Benefits: $50 per person / $150 per family per calendar year. 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?	Medical In-Network and Out-of-Area providers total out-of-pocket limit: $2,500 per person or $5,000 per family Prescription In-Network: $4,100 per person or $8,200 per family Out-of-Network* – No out-of-pocket limits **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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?	Premiums, balance billed charges, charges in excess of benefit maximums & allowed charges, penalties for non-compliance with Utilization Management programs, expenses for out-of-network providers, out-of-network deductibles, copayments & coinsurance (but emergency services in an emergency room accumulate to the in-network out-of-pocket limit), the amount of any coupon, rebate, or	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit? (continued)	other financial assistance applied directly toward a specialty drugs copayment at the time of purchase, & health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes.* See www.cignasharedadministration.com (Choose Cigna Open Access) or call Cigna at (800) 768-4695 for a list of network providers. **Out-of-network providers may be treated as network providers as required by No Surprises Act.*	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
		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	25% coinsurance	50% coinsurance	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance. Doctor on Demand is a PPO Provider Benefit only – no coverage for any online program other than Doctor on Demand. Physician office visits include in person or virtual appointments. Certain services and transplant services, including testing, may require precertification to avoid non-payment of services. See Summary Plan Description for a list of services that require precertification or call (800) 768-4695.*
	Specialist visit			
	Preventive care/screening/ immunization	No charge	Not covered	In-Network providers not subject to the deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See Summary Plan Description at for further information and for a list of all covered Preventive Services or call (800) 768-4695.* ACA required preventive services provided at a health fair or wellness gathering are paid at 100% of Plan's allowed charge.

*For more information about limitations and exceptions, see summary plan description (SPD)

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 have a test	Diagnostic test (x-ray, blood work) Imaging (CT / PET scans, MRIs)	25% coinsurance	50% coinsurance	Transplant related services, including testing, may require precertification. See Summary Plan Description for a list of services that require precertification or call (800) 768-4695.* ----------none----------
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** visit savrx.com.	Generic drugs	Retail (30-day) – 10% coinsurance ($10 min and $20 max) Retail – Walgreens Smart 90 (90-day) - $20 copayment Mail Order (90-day) – $20 copayment	You pay 100% coinsurance at time of purchase and can submit claim to Express Scripts for reimbursement.	If the cost of the drug is less than the copayment, you will only pay the cost of the drug. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements. See Summary Plan Description for a list of services that require precertification & also for Prescription Exclusions.* Drugs considered preventive services under the ACA covered at 100% & not subject to prescription drug copayment. See "the Plan for additional information & limitations. For eligible Out-of-Network prescriptions, you will be reimbursed the billed charges minus the appropriate coinsurance & copayment. If a generic equivalent is available & you choose the brand name drug, you will pay the applicable copayment plus the difference in the actual cost between the generic drug & the brand name drug. However, if your doctor believes there are special reasons you should continue using a brand name drug, he or she can request a coverage review through SavRx at 402-753-2800. If the request is approved, you will not pay more than the base copayment for the brand name drug.
	Preferred brand drugs	Retail (30-day) – 25% coinsurance ($25 min and $50 max) Retail – Walgreens Smart 90 (90-day) – $50 copayment Mail Order (90-day) – $50 copayment		
	Non-preferred brand drugs	Retail (30-day) – greater of 50% coinsurance or $50 copayment Retail – Walgreens Smart 90 (90-day) – 50% coinsurance Mail Order (90-day) – 50% coinsurance		
	Specialty drugs	(Up to 30-day supply) $35 copayment	Not covered	Specialty drugs must be preapproved by calling SavRx at 402-753-2800. Alternate copayments may apply to certain specialty drugs eligible for manufacturer discount coupons applied by at the time of purchase.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	A stay in a health care facility after outpatient surgery for more than 24 hours is considered to be an inpatient hospital service.
	Physician/ surgeon fees			Certain outpatient services, including testing, may require precertification. See Summary Plan Description for a list of services that require precertification or call (800) 768-4695.*
If you need immediate medical attention	Emergency room care	$500 copayment per ER visit and then 25% coinsurance	$500 copayment per ER visit and then 25% coinsurance unless otherwise required by No Surprises Act	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance . Doctor on Demand is an In-network benefit only – no coverage for any telemedicine program other than Doctor on Demand. Emergency room copayment is waived if patient is admitted to hospital during visit or if the patient has proof of an attempt to get treatment at a lower cost facility prior to treatment in the ER.
	Emergency medical transportation	25% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	
	Urgent care		50% coinsurance unless otherwise required by No Surprises Act	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per admission and then 25% coinsurance	$200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Elective hospital admission, including transplant services and testing, may require precertification. See Summary Plan Description at for a list of services that require precertification or call (800)768-4695.*
	Physician/ surgeon fees	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	

*For more information about limitations and exceptions, see summary plan description (SPD).

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 mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	Doctor on Demand Telehealth Program - no copayment, deductible or coinsurance. Doctor on Demand is an In-network benefit only – no coverage for any telemedicine program other than Doctor on Demand. Physician office visits include in person or virtual appointments.
	Inpatient services	$200 copayment per admission and then 25% coinsurance	Residential Treatment Program: Not covered Any other inpatient services: $200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Elective hospital admission and in-network residential treatment program admission requires precertification. See Summary Plan Description at for a list of services that require precertification or call (800) 768-4695.* You pay 100% for an out-of-network residential treatment program.
If you are pregnant	Office visits	No charge for office visits for all pregnant females.	50% coinsurance unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Cost-sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Pregnancy-related care is covered for all females. No coverage is provided for the baby of a dependent child.
	Childbirth/ delivery professional services	25% coinsurance	50% coinsurance unless otherwise required by No Surprises Act	
	Childbirth/ delivery facility services	$200 copayment per admission and then 25% coinsurance	$200 copayment per admission and then 50% coinsurance unless otherwise required by No Surprises Act	Precertification required if inpatient stay is longer than 48 hours (vaginal delivery) or 96 hours (cesarean section delivery). Pregnancy-related care is covered for all females. The deductible applies separately to both the mother and baby. No coverage is provided for the baby of a dependent child.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Plan covers part-time or intermittent skilled nursing care. Home health and home infusion therapy require precertification.
	Rehabilitation services	25% coinsurance	Outpatient: 50% coinsurance Inpatient Not covered	Outpatient physical, occupational & speech therapy combined maximum benefit of 50 visits per year. Inpatient rehabilitation requires precertification. You pay 100% for an out-of-network inpatient rehabilitation facility. Sword Health Physical Therapy - no copayment, deductible or coinsurance.
	Habilitation services	Speech therapy for childhood developmental delays: 25% coinsurance	Speech therapy for childhood developmental delays: 50% coinsurance	
	Skilled nursing care	$200 copayment per admission and then 25% coinsurance	Not covered	Maximum benefit is 70 days per calendar year. Elective admission requires precertification. You pay 100% for an out-of-network skilled nursing facility
	Durable medical equipment	25% coinsurance	50% coinsurance	Equipment repair or replacement limited to payment once in a five calendar year period. Durable medical equipment requires precertification.
	Hospice services			Covered if terminally ill. Inpatient respite max 8 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge up to $100		Limit 1 eye exam each calendar year. No coverage for retirees. Vision Benefits are an excepted benefit under HIPAA and PPACA. You can contact the Fund Office for information on how to opt out of Vision Benefits.
	Children's glasses	Frames: No charge up to $65 Lenses: No charge up to the following maximums: Single Vision: $36 Bifocal: $51 Trifocal: $65 Lenticular: $94 Contact Lenses: No charge up to $165		Limit 1 pair of frames and lenses every 24 months. Available only to active employees and their dependents if their local union has negotiated enhanced Vision Benefits. No coverage for retirees. Vision Benefits are an excepted benefit under HIPAA and PPACA. You can contact the Fund Office for information on how to opt out of Vision Benefits.
	Children's dental check-up	No charge	No charge up to Dental Plan's Reasonable & Customary Charges	$1,000 per person dental maximum. Limit 2 exams each 12 months.

*For more information about limitations and exceptions, see summary plan description (SPD).

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 • Cosmetic surgery (unless necessary due to accidental injury)	• Hearing aids • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (maximum benefit 1 surgical procedure per lifetime) • Chiropractic care (up to 20 visits/year) • Dental care	• Routine eye care (actives only, if negotiated by your local union) • Routine foot care payable when treating diabetic (metabolic) or peripheral vascular disease

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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) 768-4695.

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	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	$200
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

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	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	$400
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	**$400**
Specialist coinsurance	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	$400
Copayments	$400
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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