



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](http://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:
<a href="#">What is the overall deductible?</a>	<a href="#">In-Network</a> , <a href="#">Out-of-Network</a> * and Out-of-Area combined: \$1,500 per person per calendar year *Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. Outpatient <a href="#">Prescription Medicines</a> and <a href="#">In-Network preventive benefits</a> 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. For example, this <a href="#">plan</a> covers certain <a href="#">in-network preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	Medical <a href="#">In-Network</a> and Out-of-Area providers: \$3,000 per person or \$6,000 per family <a href="#">Prescription In-Network</a> : \$3,600 per person or \$7,200 per family <a href="#">Out-of-Network</a> * – No <a href="#">out-of-pocket limit</a> *Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.	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> <u>until</u> the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for non-compliance with Utilization Management programs, expenses for <a href="#">out-of-network providers</a> , charges above the Maximum Benefit for any plan, benefit expenses that are not included essential health benefits, the amount of any coupon, rebate, or other financial assistance applied directly toward a <a href="#">specialty drugs copayment</a> at the time of purchase, 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes*. See <a href="http://www.cignasharedadministration.com">www.cignasharedadministration.com</a> (Choose Cigna Open Access) or call Cigna at (800) 768-4695 for a list of <u>network providers</u> . * <u>Out-of-network providers</u> may be treated as <u>network providers</u> as required by No Surprises Act	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Or Out-of-Area (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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Doctor on Demand Telehealth Program - no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Doctor on Demand is an <u>In-Network</u> 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 <u>testing</u> , may require <u>precertification</u> . See Summary Plan Description for a list of services that require <u>precertification</u> or call (800) 768-4695.*
	<u>Specialist</u> visit			<u>In-Network providers</u> not subject to the <u>deductible</u> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. See Summary Plan Description for further information and for a list of all covered <u>Preventive Services</u> or call (800) 768-4695.* ACA required <u>preventive services</u> provided at a health fair or wellness gathering are paid at 100% of Plan's <u>allowed charge</u> .
	Preventive care/ <u>screening</u> /immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Transplant related services, including <u>testing</u> , may require <u>precertification</u> . See Summary Plan Description for a list of services that require <u>precertification</u> or call (800) 768-4695.*
	Imaging (CT/PET scans, MRIs)			-----none-----

\*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 Or Out-of-Area (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need <u>drugs</u> to treat your illness or condition For more information about <u>prescription drug coverage</u> visit <a href="http://savr.com">savr.com</a> .	Generic <u>drugs</u>	Retail (30-day) – 10% <u>coinsurance</u> (\$10 minimum and \$20 maximum) Retail – Walgreen's Smart 90 (90-day) \$20 <u>copayment</u> Mail Order (90-day) – \$20 <u>copayment</u>	You pay 100% <u>coinsurance</u> at time of purchase and can submit <u>claim</u> to Express Scripts for reimbursement.	If the cost of the <u>drug</u> is less than the <u>copayment</u> , you will only pay the cost of the <u>drug</u> .  Some <u>prescriptions</u> are subject to <u>preapproval</u> , quantity limits or step therapy requirements. See Summary Plan Description for a list of services that require <u>precertification</u> and for <u>Prescription Exclusions</u> or call 402-753-2800.*
	Preferred brand <u>drugs</u>	Retail (30-day) – 25% <u>coinsurance</u> (\$25 minimum and \$50 maximum) Retail – Walgreen's Smart 90 (90-day) \$50 <u>copayment</u> Mail Order (90-day) – \$50 <u>copayment</u>		<u>Drugs</u> considered <u>preventive services</u> under the ACA covered at 100% and not subject to <u>prescription drug copayment</u> . See the <u>Plan</u> for additional limitations.*  For eligible <u>Out-of-Network prescriptions</u> , you will be reimbursed the billed charges minus the appropriate <u>coinsurance</u> and <u>copayment</u> .
	Non-preferred brand <u>drugs</u>	Retail (30-day) – greater of 50% of <u>drug</u> cost or \$50 <u>copayment</u> Retail – Walgreen's Smart 90 (90-day) 50% of <u>drug</u> cost Mail Order (90-day) – 50% of <u>drug</u> cost		If a generic equivalent is available and you choose the brand name <u>drug</u> , you will pay the applicable <u>copayment</u> plus the difference in the actual cost between the generic <u>drug</u> and the brand name <u>drug</u> . However, if your doctor believes there are special reasons you should continue using a brand name <u>drug</u> , he or she can request a coverage review by calling SavRx at 402-753-2800. If the request is approved, you will not pay more than the base <u>copayment</u> for the brand name <u>drug</u> .
	<u>Specialty drugs</u>	(Up to 30-day supply) \$35 <u>copayment</u>	Not covered	<u>Specialty drugs</u> must be <u>preapproved</u> by calling SavRx at 402-753-2800. Alternate <u>copayments</u> may apply to certain <u>specialty drugs</u> eligible for manufacturer discount coupons applied by at the time of purchase.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u> 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 <u>hospital</u> service.

\*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 Or Out-of-Area (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/ surgeon fees			Certain outpatient services, including <a href="#">testing</a> , may require <a href="#">precertification</a> . See Summary Plan Description for a list of services that require <a href="#">precertification</a> or call (800) 768-4695.*
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copayment</a> per ER visit and then 30% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> per ER visit and then 30% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	Doctor on Demand Telehealth Program - no <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> . Doctor on Demand is an <a href="#">In-network</a> benefit only – no coverage for any telemedicine program other than Doctor on Demand. Emergency room <a href="#">copayment</a> 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.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	
	<a href="#">Urgent care</a>		50% <a href="#">coinsurance</a> unless otherwise required by No Surprises Act	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <a href="#">copayment</a> per admission and then 30% <a href="#">coinsurance</a>	\$200 <a href="#">copayment</a> per admission and then 50% <a href="#">coinsurance</a>	Benefits based on hospital's average semi-private room rate. Elective hospital admission, including transplant services and testing, may require <a href="#">precertification</a> . See Summary Plan Description for a list of services that require <a href="#">precertification</a> or call (800) 768-4695.*
	Physician/ surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\*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 Or Out-of-Area (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	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	Doctor on Demand Telehealth Program- no <a href="#">copayment, deductible or coinsurance</a> . Doctor on Demand is an <a href="#">in-network</a> 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 <a href="#">copayment</a> per admission and then 30% <a href="#">coinsurance</a>	Residential Treatment Program: Not covered  Any other inpatient services: \$200 <a href="#">copayment</a> per admission and then 50% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	Elective hospital admission and <a href="#">in-network</a> residential treatment program admission requires <a href="#">precertification</a> . See Summary Plan Description for a list of services that require <a href="#">precertification</a> or call (800) 768-4695.* You pay 100% for an <a href="#">out-of-network</a> residential treatment program.
If you are pregnant	Office visits	No charge for office visits for all pregnant females.	50% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). <a href="#">Cost-sharing</a> does not apply to <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or a <a href="#">deductible</a> 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	\$200 <a href="#">copayment</a> per admission and then 30% <a href="#">coinsurance</a>	\$200 <a href="#">copayment</a> per admission and then 50% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	<a href="#">Precertification</a> 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 <a href="#">deductible</a> applies separately to both the mother and baby. No coverage is provided for the baby of a dependent child.
	Childbirth/ delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance unless otherwise required by No Surprises Act</a>	

\*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 Or Out-of-Area (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	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan covers part-time or intermittent <a href="#">skilled nursing care</a> . <a href="#">Home health</a> and home infusion therapy require <a href="#">precertification</a> .	
	<a href="#">Rehabilitation services</a>		Outpatient: 50% <a href="#">coinsurance</a> Inpatient: Not covered	Outpatient physical, occupational & speech therapy combined maximum benefit of 50 visits per year. Inpatient rehabilitation requires <a href="#">precertification</a> . You pay 100% for an <a href="#">out-of-network</a> inpatient rehabilitation facility. Sword Health Physical Therapy - no <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> .	
	<a href="#">Habilitation services</a>	Speech therapy for childhood developmental delays: 30% <a href="#">coinsurance</a>	Speech therapy for childhood developmental delays: 50% <a href="#">coinsurance</a>		
	<a href="#">Skilled nursing care</a>	\$200 <a href="#">copayment</a> per admission and then 30% <a href="#">coinsurance</a>	Not covered	Maximum benefit is 70 days per calendar year. Elective admission requires <a href="#">precertification</a> . You pay 100% for an <a href="#">out-of-network</a> <a href="#">skilled nursing</a> facility	
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Equipment repair or replacement limited to payment once in a five calendar year period. Durable medical equipment requires <a href="#">precertification</a> .	
	<a href="#">Hospice services</a>			Covered if terminally ill. Inpatient respite max 8 days per lifetime.	
If your child needs dental or eye care	Children's eye exam	Not covered		You pay 100% for these expenses. Eye exam may be covered if conducted during <a href="#">preventive care</a> office visit.	
	Children's glasses	Not covered		You pay 100% for these expenses.	
	Children's dental check-up				

## 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"><li>• Acupuncture</li><li>• Chiropractic care</li><li>• Cosmetic surgery (unless necessary due to accidental injury)</li><li>• Dental care (adult or child)</li></ul>	<ul style="list-style-type: none"><li>• Eyeglasses</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private duty nursing</li><li>• Routine eye care (adult or child)</li><li>• Weight loss programs</li></ul>
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### 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"><li>• Bariatric surgery (maximum benefit 1 surgical procedure per lifetime)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care payable when treating diabetic (metabolic) or peripheral vascular disease</li></ul>
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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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), 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 (800) 768-4695 or the Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://Marketplace.gov).

### Language Access Services:

Para obtener asistencia en Español, llame al (800) 768-4695.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,960</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,120</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,910</b>

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