

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**  
**Arizona Pipe Trades Health and Welfare Trust Fund: PPO**

**Coverage Period: 01/01/2025 - 12/31/2025**  
**Coverage for: Individual/Individual + Family | Plan Type: PPO**



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, go online at [www.cigna.com/sp](http://www.cigna.com/sp). 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-Cigna24 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| What is the overall <a href="#">deductible</a> ?                                | \$0   | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | No.   | You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.  |
| 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> : \$4,800/individual or \$9,600/family<br>For <a href="#">out-of-network providers</a> : \$4,800/individual or \$9,600/family<br>For <a href="#">prescription drugs</a> : \$2,350/individual or \$4,700/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> ?               | Penalties for failure to obtain <a href="#">pre-authorization</a> for services, certain drug coupon amounts, <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.cigna.com">www.cigna.com</a> or call 1-800-Cigna24 for a list of <a href="#">network providers</a> .   | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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> .   |

| Common Medical Event  | Services You May Need                                    | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness         | No charge/visit  | No charge  | None   |
|   | <a href="#">Specialist</a> visit                         | No charge/visit  | No charge  | None   |
|   | <a href="#">Preventive care/ screening/ immunization</a> | No charge  | Not covered  | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)      | No charge  | No charge  | None   |
|   | Imaging (CT/PET scans, MRIs)                             | No charge  | No charge  | None   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com">www.cigna.com</a> | Generic drugs (Tier 1)                                   | No charge/prescription (retail 30 days), No charge/prescription (retail & home delivery 90 days) | No Charge (retail); Not covered (home delivery)    | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a> . Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.<br><br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br><br>In-network Federally required preventive drugs will be provided at no charge. |
|   | Preferred brand drugs (Tier 2)                           | No charge/prescription (retail 30 days), No charge/prescription (retail & home delivery 90 days) | No Charge (retail); Not covered (home delivery)    |  |
|   | Non-preferred brand drugs (Tier 3)                       | No charge/prescription (retail 30 days), No charge/prescription (retail & home delivery 90 days) | No Charge (retail); Not covered (home delivery)    |  |
|   | <a href="#">Specialty drugs</a> (Tier 4)                 | No charge/prescription (retail & home delivery 30 days)  | No Charge (retail); Not covered (home delivery)    |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)           | No charge  | No charge  | None   |
|   | Physician/surgeon fees                                   | No charge  | No charge  | None   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                      | No charge/visit  | No charge/visit                                    | Out-of-network services are paid at the in-network cost share.   |

| Common Medical Event  | Services You May Need                            | What You Will Pay                                      |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | In-Network Provider<br>(You will pay the least)        | Out-of-Network Provider<br>(You will pay the most)     |  |
|   | <a href="#">Emergency medical transportation</a> | No charge  | No charge  | Out-of-network air ambulance services are paid at the in-network cost share.   |
|   | <a href="#">Urgent care</a>                      | No charge/visit  | No charge/visit  | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | No charge  | No charge  | \$250 penalty for no out-of-network precertification.  |
|   | Physician/surgeon fees                           | No charge  | No charge  | \$250 penalty for no out-of-network precertification.  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge/office visit<br>No charge/all other services | No charge/office visit<br>No charge/all other services | \$250 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.   |
|   | Inpatient services                               | No charge  | No charge  | \$250 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.   |
| If you are pregnant   | Office visits                                    | No charge  | No charge  | Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.<br><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .<br>Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services        | No charge  | No charge  |  |
|   | Childbirth/delivery facility services            | No charge  | No charge  |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No charge  | No charge  | 16 hour maximum per day  |

| Common Medical Event                   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | In-Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most)            |  |
|  | <a href="#">Rehabilitation services</a>   | No charge/visit   | No charge/visit   | Coverage is limited to annual max of: 50 days for <a href="#">Rehabilitation</a> and Cardiac rehab services; 25 days for Chiropractic care services.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
|  | <a href="#">Habilitation services</a>     | No charge/visit   | No charge/visit   | Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.          |
|  | <a href="#">Skilled nursing care</a>      | No charge   | Not covered   | \$250 penalty for no out-of-network precertification.<br>Coverage is limited to 60 days annual max.  |
|  | <a href="#">Durable medical equipment</a> | No charge   | No charge   | None   |
|  | <a href="#">Hospice services</a>          | No charge/inpatient services<br>No charge/outpatient services | No charge/inpatient services<br>No charge/outpatient services | \$250 penalty for no out-of-network precertification.  |
| If your child needs dental or eye care | Children's eye exam                       | Not covered   | Not covered   | None   |
|  | Children's glasses                        | Not covered   | Not covered   | None   |
|  | Children's dental check-up                | Not covered   | Not covered   | None   |

## 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](#).)

- |                          |  |                            |
|--------------------------|--|----------------------------|
| • Cosmetic surgery       | • Infertility treatment                              | • Routine eye care (Adult) |
| • Dental care (Adult)    | • Long-term care                                     | • Routine foot care        |
| • Dental care (Children) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs     |
| • Eye care (Children)    | • Private-duty nursing                               |                            |

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

- |                                       |                               |  |
|---------------------------------------|-------------------------------|--|
| • Acupuncture (20 days)               | • Chiropractic care (25 days) | • Hearing aids (\$1,300 maximum per hearing aid per 36 month Maximum of 2 devices per 36 months) |
| • Bariatric Surgery (in-network only) |                               |  |

### **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: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-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](#). 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 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: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-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](#).

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

*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 [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

*Cost Sharing*

|                             |     |
|-----------------------------|-----|
| <a href="#">Deductibles</a> | \$0 |
| <a href="#">Copayments</a>  | \$0 |
| <a href="#">Coinsurance</a> | \$0 |

*What isn't covered*

|                                   |             |
|-----------------------------------|-------------|
| Limits or exclusions              | \$20        |
| <b>The total Peg would pay is</b> | <b>\$20</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

*Cost Sharing*

|                             |     |
|-----------------------------|-----|
| <a href="#">Deductibles</a> | \$0 |
| <a href="#">Copayments</a>  | \$0 |
| <a href="#">Coinsurance</a> | \$0 |

*What isn't covered*

|                                   |             |
|-----------------------------------|-------------|
| Limits or exclusions              | \$40        |
| <b>The total Joe would pay is</b> | <b>\$40</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

*Cost Sharing*

|                             |     |
|-----------------------------|-----|
| <a href="#">Deductibles</a> | \$0 |
| <a href="#">Copayments</a>  | \$0 |
| <a href="#">Coinsurance</a> | \$0 |

*What isn't covered*

|                                   |            |
|-----------------------------------|------------|
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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





# Discrimination is against the law.

## Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.



If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

### Cigna Healthcare

Nondiscrimination Complaint Coordinator  
P.O. Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

**U.S. Department of Health and Human Services** 200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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## Proficiency of Language Assistance Services

**English** - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, llame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** - /± : ft{F -a:T:mf&i.f .Jtm{:#: fU@ ° ftm- Cigna Healthcare E!'jffj!f] p, § fflf@.:El'j ID -tc lfilEl'j51,'c\$° 1ili p\$'Jli ffl 1.800.244.6224 lufi!\*I : ti 711) °

**Vietnamese** - XIN LU'U Y: Quy vi dU'Q'C clip dich v1,1 trq giup v ngon ngfr mien phi. Danh cho khach hang hi\$ n t i cua Cigna Healthcare, vui long goi s6 a m it sau the Hoi vien. Cac trll'ang hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

**Korean-?£1: Oj .A. -\$-o "I -f:lq., <2:l0j :;x::1 }..il::lIA E.£ Ol-\$-o -? £/ Liq. -ri;H Cigna Healthcare 7 :;i:: \::J J l'i ID :1c OJI £/ 2 .2..£ '2:1stoH?{J"l2.. 7IE q -f:lq.011 1.800.244.6224 (TTY: qo1 711)9£ 2 OH?{J.A.l2..**

**Tagalog** - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card.0 kaya, tumawag sa 1.800.244.6224 (TTY: l-dial ang 711).

**Russian** - BHv1MAHv1E: BaM MoryT npeAOCTaBVITb 6ecn.naTHble ycnprn nepeBoP,a. Ec.nvi Bbl y)(e y4acTByeTe B n.naHe Cigna Healthcare, no3BOHVITe no HOMepy, yKa3aHHOMY Ha o6paTHOVI CTOpOHe BaweVI VIA8HTVIQ)VIKaI..VIOHHOVI KapTO4KVI y4aCTHVIKa n.naHa. Ec.nvi Bbl He s:lBmleTeCb y4aCTHVIKOM OAHOro VI3 HaWVIX n.naHOB, no3BOHVITe no HOMepy 1.800.244.6224 (TTY: 711).

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**French Creole** - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS: composez le numero 711).

**Portuguese** - ATENCAO: Tern ao seu dispor servic;;os de assistencia linguistica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identificac;;ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** - UWAGA: w celu skorzystania z dost pnej, bezpfatnej pomocy j zykowej, obecni klienci firmy Cigna Healthcare mogg dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** - 51 \$ : E3;,\$::ifi i3 :h '8-, OJ :/i-t:t- t::Z c'flJffil,'tctaf\*9 ° I :r±O)Cigna HealthcareO);s;g::m ;;t IDtJ- E mjO) i3ffi "'c', ;;s i3ti::Tc'il (tc. l,'o i"O){h0)15tt, 1.800.244.6224 (TTY: 711) "'c', s i3ti::Tc'il ( tc. l,'a

**Italian** - ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Peri clienti Cigna Healthcare attuali, chiamare ii numero sul retro della tessera di identificazione. In caso contrario, chiamare ii numero 1.800.244.6224 (utenti TTY: chiamare ii numero 711).

**German** - ACHTUNG: Die Leistungen der Sprachunterstutzung stehen Ihnen kostenlos zur VerfOgung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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