



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 to www.harrisonbenefits.org or call in Portland (503) 224-0048 or toll-free 1-800-547-4457. 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 www.cciio.cms.gov or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 person/\$1,000 family (2 or more persons) If elected, Flexible Benefits Plan may be used for reimbursement of your deductible.	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. Most network provider preventive care services 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 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?	No.	
What is the out-of-pocket limit for this plan?	For network providers or out-of-network providers : <ul style="list-style-type: none"> • \$3,000 person/\$6,000 family for medical in-network • \$3,000 person/\$6,000 family for medical out-of-network • \$3,000 person/\$6,000 family for prescriptions If elected, your Flexible Benefits Plan may be used for reimbursement of your out-of-pocket expenses.	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-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. For a list of network providers , see www.mycigna.com , or call 1-800-547-4457.	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 permission from this plan .



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 (including virtual visits)	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	Not covered	Deductible does not apply. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harrisonbenefits.org	Preferred and non-preferred generic drugs	Retail: \$15 copay /prescription; Mail order: \$30 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If elected, your Flexible Benefits Plan may be used for reimbursement of prescription drug copayments.
	Preferred brand drugs	Retail: \$35 copay /prescription; Mail order: \$70 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a brand with generic equivalent is selected, the cost difference between the two will be added to the member copay. Unless the prescriber writes on the prescription "dispense as written".
	Non-preferred brand drugs	Retail: \$70 copay /prescription; Mail order: \$140 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a brand with generic equivalent is selected, the cost difference between the two will be added to the member copay. Unless the prescriber writes on the prescription "dispense as written".
	Specialty drugs	\$150 copay /prescription	Not covered	Must use Credena Health. Call (503) 962-1700 for more information. Maximum 30-day supply.

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)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	\$250 copay if not admitted except for certain medical conditions.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	Limited to the U.S. and Canada.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization recommended except in an emergency. See your plan document for details.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	See your plan document for details.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization recommended except in an emergency. See your plan document for details.
If you are pregnant	Office visits	No charge	40% coinsurance after deductible	Coinsurance applies to provider delivery charges.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum of 100 visits per calendar year.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Routine custodial care excluded. Limitations apply – See your plan document.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Equipment purchase requires review for medical necessity.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	None.

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 your child needs dental or eye care	Children's eye exam	\$25 copay /visit	100% of cost in excess of \$50	Limited to 1 exam every 12 months.
	Children's glasses	Frames covered up to \$150.	Various reimbursement amounts. Refer to Plan Document.	Limited to every 12 months for lenses, 12 months for frames.
	Children's dental check-up (Trust Dental)	No charge	No charge -	2 exams per calendar year
	Children's dental check-up (Kaiser Dental)	\$10 copay /visit	Not covered	Question? In Portland (503) 813-2000 or toll-free 1-800-813-2000
	Children's dental check-up (Willamette Dental)	\$10 copay /visit	Not covered	Question? Toll-free 1-855-433-6825

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 is generally excluded except as required by Women's Health and Cancer Rights Act, due to an accidental bodily injury, or due to a birth defect.
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight Loss Programs
- Routine Foot Care

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

- Acupuncture Services
- Bariatric Surgery
- Dental Care
- Chiropractic Care
- Hearing Aids
- Naturopathic Services
- Most coverage provided outside the United States. See www.harrisonbenefits.org.

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <http://www.cciio.cms.gov>. 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: Harrison Electrical Workers Trust Fund administrative office at (503) 224-0048 or 1-800-457-4457. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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](#).

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	\$500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$12,800
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[In this example, Peg would pay:](#)

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinurance	\$2,460
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,960

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$7,400
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[In this example, Joe would pay:](#)

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinurance	\$1,380
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,880

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	20%
■ 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	\$1,900
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[In this example, Mia would pay:](#)

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$780