




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, [insert contact information]. 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 (800) 628-6562 to request a copy

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| <p>What is the overall deductible?</p> | <p>In-Network, Out-of-Network and Out-of-Area combined: \$400 per person / \$1,200 per family per calendar year</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Outpatient Prescription Medicines and in-network preventive benefits are covered before you meet your deductible.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>Yes. Dental Benefits: \$50 per person / \$150 per family per calendar year. There are no other specific deductibles.</p> | <p>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.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>Medical In-Network and Out-of-Area providers out-of-pocket limit for coinsurance: \$2,000 per person 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</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Medical In-Network & Out-of-Area providers out-of-pocket limit for coinsurance: premiums, balance billed charges, copayments, deductibles, charges in excess of benefit maximums & allowed charges, penalties for non-compliance with Utilization Management programs, expenses for out-of-network providers, outpatient</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| | <p>prescription drug expenses & health care this plan doesn't cover.</p> <p>Medical In-Network & Out-of-Area providers total 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, outpatient prescription drug expenses, 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 other financial assistance applied directly toward a specialty drugs copayment at the time of purchase, & health care this plan doesn't cover.</p> | |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See www.cignasharedadministration.com (Choose Cigna Open Access) or call Cigna at (800) 768-4695 for a list of network providers.</p> | <p>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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No</p> | <p>You can see the specialist you choose without a referral.</p> |

 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) | |
| <p>If you visit a health care provider's office or clinic</p> | <p>Primary care visit to treat an injury or illness</p> | <p>25% coinsurance</p> | <p>50% coinsurance</p> | <p>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. Certain services and transplant services, including testing, may require precertification to avoid non-payment of services. See Summary Plan Description</p> |
| | <p>Specialist visit</p> | <p>25% coinsurance</p> | <p>50% coinsurance</p> | |

| 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) | |
| | | | | at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* |
| | 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 Article VII for further information and for a list of all covered Preventive Services or call (800) 628-6562.* ACA required preventive services provided at a health fair or wellness gathering are paid at 100% of Plan's allowed charge . |
| If you have a test | Diagnostic test (x-ray, blood work) | 25% coinsurance | 50% coinsurance | Transplant related services, including testing , may require precertification . See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* No deductible , copayment or coinsurance on COVID-19 testing at any provider (in-network or out-of-network). |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 50% coinsurance | Diagnostic radiology, like CT, PT, MRI scans & nuclear radiology services & transplant related services, including testing , may require precertification . See Plan Doc at Art IX, Sec 5 for a list of services that require precertification or call (800) 628-6562.* |
| If you need drugs to treat your illness or condition For more information about prescription drug coverage contact Express Scripts at (855) 202-9582 or visit www.express-scripts.com . | Generic drugs | Retail (30-day) – 10% coinsurance (\$10 min and \$20 max) Retail – Walgreen's 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 at Article IX, Section 5 for a list of services that require precertification & Article X, Section 2G for Prescription Exclusions.* Drugs considered preventive services under the ACA covered at 100% & not subject to prescription drug copayment . See "Drug Row" in Article VII of the Plan , Article VI, Section 13 of the Plan & Amendment No. 6 |
| | Preferred brand drugs | Retail (30-day) – 25% coinsurance (\$25 minimum and \$50 | You pay 100% coinsurance at time of purchase and can submit | |

*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) | |
| | | maximum) Retail – Walgreen’s Smart 90 (90-day) \$50 copayment Mail Order (90-day) – \$50 copayment | claim to Express Scripts for reimbursement. | to 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 the online portal available at www.esrx.com/PA . If the request is approved, you will not pay more than the base copayment for the brand name drug . Specialty drugs must be preapproved by calling Express Scripts at (855) 202-9582. Alternate copayments may apply to certain specialty drugs eligible for manufacturer discount coupons applied by Express Scripts at the time of purchase. |
| | Non-preferred brand drugs | Retail (30-day) – greater of 50% coinsurance or \$50 copayment Retail – Walgreen’s Smart 90 (90-day) 50% coinsurance Mail Order (90-day) – 50% coinsurance | You pay 100% coinsurance at time of purchase and can submit claim to Express Scripts for reimbursement. | |
| | Specialty drugs | (Up to 30-day supply) \$35 copayment | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 50% coinsurance | 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 | 25% coinsurance | 50% coinsurance | Certain outpatient services, including testing , may require precertification . See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* |
| 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 | 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. |
| | Emergency medical transportation | 25% coinsurance | 50% coinsurance | |
| | Urgent care | 25% coinsurance | 50% coinsurance | |
| If you have a hospital | Facility fee (e.g., | \$200 copayment | \$200 copayment | Benefits based on hospital’s average semi-private |

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| 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) | |
| stay | hospital room) | per admission and then 25% coinsurance | per admission and then 50% coinsurance | room rate. Elective hospital admission, including transplant services and testing, may require precertification . See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 25% coinsurance | 50% coinsurance | 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. |
| | 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 | Elective hospital admission and in-network residential treatment program admission requires precertification . See Summary Plan Description at Article IX, Section 5 for a list of services that require precertification or call (800) 628-6562.* 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 | 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 | |
| | Childbirth/delivery facility services | \$200 copayment per admission and then 25% coinsurance | \$200 copayment per admission and then 50% coinsurance | |
| 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 | Outpatient physical, occupational & speech therapy combined maximum benefit of 50 visits per year. |

*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) | |
| | Habilitation services | Speech therapy for childhood developmental delays: 25% coinsurance | Inpatient: Not covered Speech therapy for childhood developmental delays: 50% coinsurance | Inpatient rehabilitation and outpatient speech therapy require precertification . You pay 100% for an out-of-network inpatient rehabilitation facility. |
| | 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 | 25% coinsurance | 50% coinsurance | 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 | 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 \$50, then 90% coinsurance Lenses: No charge up to the following maximums, then 90% coinsurance Single Vision: \$30 Bifocal: \$40 Trifocal: \$55 Lenticular: \$80 | Frames: No charge up to \$50, then 90% coinsurance Lenses: No charge up to the following maximums, then 90% coinsurance Single Vision: \$30 Bifocal: \$40 Trifocal: \$55 Lenticular: \$80 | 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](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery (unless necessary due accidental injury)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Out-of-network residential treatment program, skilled nursing facility and inpatient rehab facility• 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.)

- | | |
|--|--|
| <ul style="list-style-type: none">• Bariatric surgery (maximum benefit 1 surgical procedure per lifetime)• Chiropractic care (up to 20 visits/year)• Dental care | <ul style="list-style-type: none">• 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) 628-6562.

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$400 |
| Copayments | \$200 |
| Coinsurance | \$1,300 |
| <i>What isn't covered</i> | |
| 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$400 |
| Copayments | \$400 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$400 |
| Copayments | \$400 |
| Coinsurance | \$500 |
| <i>What isn't covered</i> | |
| 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.