



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.** If you want more detail about your coverage and costs, check your Summary Plan Description, visit our website at www.iambfo.org, call Cigna HealthCare at 1-800-Cigna24 (1-800-244-6224) or contact the Fund Office at 1-800-457-3481. 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
<p>What is the overall deductible?</p>	<p>For in-network providers and out-of-network providers: \$100 individual / \$200 family</p>	<p>Generally, you must pay all of the costs from providers up to the individual 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. In-network preventive care and immunizations, prescription drugs through CVS Caremark, and in-network services where a copayment applies 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 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>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers: \$1,600 individual / \$3,200 family For out-of-network providers: \$3,100/individual / \$6,200 family For prescription drugs through CVS Caremark: \$1,600 individual / \$3,200 family</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>Premiums, balance billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

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Important Questions	Answers	Why This Matters
Will you pay less if you use a network provider ?	Yes. See www.myCigna.com or call 1-800-Cigna24 for a list of network providers .	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 [coinsurance](#) costs shown below are after your [deductible](#) has been met, if [deductible](#) applies. [Deductible](#) does not apply to services with [copayments](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		In-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	\$5 copay /visit	30% coinsurance	Virtual telehealth visit – \$10 copayment, deductible does not apply if from a Cigna Telehealth Connection Physician. Refer to the policy for more information.
	Specialist visit	\$10 copay /visit	30% coinsurance	Limits apply for some services.
	Preventive care/ screening/ immunizations	No charge/visit** No charge/screening** No charge/immunizations** ** Deductible does not apply	30% coinsurance /visit** 30% coinsurance /screening** 30% coinsurance /immunizations** ** Deductible does not apply	Various age and frequency limits. 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 (blood work, x-rays, ultrasounds, etc.)	10% coinsurance (Ind. Facility) Office visit copay (Physician's Office)	30% coinsurance	Includes Radiologist and Pathologist technical fees.
	Imaging (CT/PET scans, MRIs, etc.)	10% coinsurance (Ind. Facility) Office visit copay (Physician's Office)	30% coinsurance	Preauthorization required.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition Call CVS Caremark at 1-800-282-8503 for information about Mail-Order and about what needs preauthorization .	Generic drugs (Tier 1; No copay for contraceptives)	\$10 copay for 34-day supply \$20 copay for 90-day supply	\$10 copay for 34-day supply	34-day supply can be obtained from all retail pharmacies.
	Preferred drugs (Tier 2)	\$20 copay for 34-day supply \$30 copay for 90-day supply	\$20 copay for 34-day supply	90-day supply is available only for maintenance drugs obtained from Mail-Order or at CVS pharmacies.
	Non-preferred drugs (Tier 3)	\$30 copay for 34-day supply \$40 copay for 90-day supply	\$30 copay for 34-day supply	Preauthorization is required for many medications.
	Specialty drugs (Tier 4)	\$40 copay /prescription	\$40 copay /prescription	Preauthorization and specialty pharmacy use is required for all specialty drugs. Call CVS Caremark at 1-800-237-2767 for information.
If you have outpatient surgery	Facility fee (ambulatory surgery center, outpatient hospital facility, etc.)	\$50 copay /visit surgery center, outpatient hospital, etc.	30% coinsurance	Preauthorization required for some services.
	Physician/surgeon fees	Facility copay covers surgical professional fees	30% coinsurance	Preauthorization required for some services. If surgery is performed in physician's office, the applicable office visit copay applies.
If you need immediate medical attention	Emergency room care	\$50 copay /visit	\$50 copay /visit (30% coinsurance if not a true emergency medical condition)	Emergency room copay is waived if you are admitted to the hospital.
	Emergency medical transportation	10% coinsurance	30% coinsurance	None
	Urgent care	\$25 copay /visit	30% coinsurance	None

Questions? For more information about your prescription drug coverage you can register at www.caremark.com or you can call the CVS Caremark Customer Care line at 1-800-282-8503. Or you can contact the Fund Office at 1-800-457-3481.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Inpatient hospital facility	\$75 <u>copay</u> /admission	30% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Outpatient hospital facility	\$50 <u>copay</u> /visit	30% <u>coinsurance</u>	<u>Preauthorization</u> required for some services.
	Physician/surgeon fees	Most covered by applicable facility <u>copay</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for some services; most covered <u>in-network provider</u> services are covered by inpatient facility <u>copay</u> . Some surgical procedures limited to in-network only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <u>copay</u> /primary care visit \$10 <u>copay</u> / <u>specialist</u> visit \$50 <u>copay</u> /outpatient facility	30% <u>coinsurance</u>	<u>Preauthorization</u> required for some services. Virtual telehealth visit – \$10 copayment, deductible does not apply if from a Cigna Telehealth Connection Physician. Refer to the policy for more information.
	Inpatient services	\$75 <u>copay</u> /admission	30% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	Primary care or <u>specialist copay</u> applies for initial visit and any visits billed outside of delivery fee	30% <u>coinsurance</u>	<u>Preauthorization</u> required for some services. Depending on the type of service needed, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in this SBC.
	Childbirth/delivery professional services	Facility <u>copay</u> covers surgical delivery professional fee	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$75 <u>copay</u> /admission	30% <u>coinsurance</u>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		In-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	10% coinsurance	30% coinsurance	Coverage of a home health aide as part of an approved treatment program is limited to 40 visits per year. Other limitations apply and preauthorization required.
	Rehabilitation services	\$10 copay /visit	30% coinsurance	Preauthorization required. Coverage is limited to annual max of 50 days of combined rehab services (speech, physical and occupational therapies, cardiac rehab, etc.).
	Habilitation services	Not covered	Not covered	No coverage
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization required. Admission must be within 7 days of a 5-day or more inpatient stay. Coverage is limited to 50% of prior acute care hospitals average semi-private room rate (or negotiated rate) and is limited to 100 days annual max.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization required. Rental limited to purchase price.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization required and some limitations apply.
If your child needs dental care or routine eye care	Children's eye exam	Not covered	Not covered	No coverage
	Children's glasses	Not covered	Not covered	No coverage
	Children's dental check-up	Not covered	Not covered	No coverage

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Excluded Services and 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
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services — This is not a complete list — Please see your [plan](#) document)

- Acupuncture (for pain diagnosis)
- Bariatric surgery (in-network only)
- Chiropractic care (20 days)
- Emergency and non-emergency care when traveling outside the U.S.
- Hearing Aids
- Private duty nursing

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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 1-866-444-EBSA (3272) or 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 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 questions about your rights, this notice, or assistance, you can 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. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: DC Office of the Health Care Ombudsman and Bill of Rights at 877-685-6391. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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.* -----

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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](#) \$100
- [Specialist copayment](#) \$10
- Hospital (inpatient) [copayment](#) \$75
- Other [coinsurance](#) 10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$90
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$350

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$10
- Hospital (inpatient) [copayment](#) \$75
- Other [coinsurance](#) 10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$810
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$920

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$10
- Hospital (inpatient) [copayment](#) \$75
- Other [coinsurance](#) 10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$140
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$340

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

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