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
What is the overall deductible?	For in-network providers and out-of-network providers: **$100** individual / **$200** family	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.
Are there services covered before you meet your deductible?	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.	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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	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	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.

Questions? Call the Fund Office at 1-800-457-3481 or visit our website at www.iambfo.org. If you are unclear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the Benefit Trust Fund at 1-800-457-3481 to request a copy.

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.

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. 90-day supply is available only for maintenance drugs obtained from Mail-Order or at CVS pharmacies. Preauthorization is required for many medications.
	Preferred drugs (Tier 2)	$20 copay for 34-day supply $30 copay for 90-day supply	$20 copay for 34-day supply	
	Non-preferred drugs (Tier 3)	$30 copay for 34-day supply $40 copay for 90-day supply	$30 copay for 34-day supply	
	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 an emergency medical condition)	Emergency room copay is waived if you are admitted to the hospital. You may contact the No Surprises Help Desk at 1-800-985-3059.
	Emergency medical transportation	10% coinsurance for air ambulance; 10% coinsurance for other types of emergency medical transportation	10% coinsurance for air ambulance; 30% coinsurance for other types of emergency medical transportation	None
	Urgent care	$25 copay/visit	30% coinsurance	None

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 copay/admission	30% coinsurance	Preauthorization required.
	Outpatient hospital facility	$50 copay/visit	30% coinsurance	Preauthorization required for some services.
	Physician/surgeon fees	Most covered by applicable facility copay	30% coinsurance	Preauthorization required for some services; most covered in-network provider services are covered by inpatient facility copay. Some surgical procedures limited to in-network only.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/primary care visit $10 copay/specialist visit $50 copay/outpatient facility	30% coinsurance	Preauthorization 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 copay/admission	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	Primary care or specialist copay applies for initial visit and any visits billed outside of delivery fee	30% coinsurance	Preauthorization required for some services. Depending on the type of service needed, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in this SBC.
	Childbirth/delivery professional services	Facility copay covers surgical delivery professional fee	30% coinsurance	
	Childbirth/delivery facility services	$75 copay/admission	30% coinsurance	

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

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	• Hearing aids	• Routine eye care (Children)
• Dental care (Adult)	• Infertility treatment	• Routine foot care
• Dental care (Children)	• Long-term care	• Surgical vision correction
• Habilitation services	• Routine eye care (Adult)	• 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)	• Emergency and non-emergency care when traveling outside the U.S.
• Bariatric surgery (in-network only)	• Private duty nursing
• Chiropractic care (20 days)	

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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, kwiijigo 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** **$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$90
Coinsurance	$100
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$810
Coinsurance	$10
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$140
Coinsurance	$100
What isn't covered	
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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