



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](http://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><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>For <a href="#">in-network providers</a> and <a href="#">out-of-network providers</a>:  <b>\$100</b> individual / <b>\$200</b> family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the individual <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. In-network <a href="#">preventive care</a> and immunizations, <a href="#">prescription drugs</a> through CVS Caremark, and in-network services where a <a href="#">copayment</a> applies are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">in-network providers</a>: <b>\$1,600</b> individual / <b>\$3,200</b> family                      For <a href="#">out-of-network providers</a>: <b>\$3,100</b> individual / <b>\$6,200</b> family                       For <a href="#">prescription drugs</a> through CVS Caremark: <b>\$1,600</b> individual / <b>\$3,200</b> family</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

**Questions?** Call the Fund Office at 1-800-457-3481 or visit our website at [www.iambfo.org](http://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](http://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 <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.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> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$5 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Virtual telehealth visit – \$10 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply if from a Cigna Telehealth Connection Physician. Refer to the policy for more information.
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Limits apply for some services.
	<a href="#">Preventive care/ screening/ immunizations</a>	No charge/visit** No charge/screening** No charge/immunizations**  ** <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> /visit** 30% <a href="#">coinsurance</a> /screening** 30% <a href="#">coinsurance</a> /immunizations**  ** <a href="#">Deductible</a> does not apply	Various age and frequency limits.  You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive; then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (blood work, x-rays, ultrasounds, etc.)	10% <a href="#">coinsurance</a> (Ind. Facility) Physician's Office visit <a href="#">copay</a>	30% <a href="#">coinsurance</a>	Includes Radiologist and Pathologist technical fees.
	Imaging (CT/PET scans, MRIs, etc.)	10% <a href="#">coinsurance</a> (Ind. Facility) Physician's Office visit <a href="#">copay</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> 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)	
<b>If you need drugs to treat your illness or condition</b>  Call CVS Caremark at 1-800-282-8503 for information about Mail-Order and about what needs <a href="#">preauthorization</a> .	Generic drugs (Tier 1; No copay for contraceptives)	\$10 <a href="#">copay</a> for 34-day supply \$20 <a href="#">copay</a> for 90-day supply	\$10 <a href="#">copay</a> 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. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). <a href="#">Preauthorization</a> is required for many medications.
	Preferred drugs (Tier 2)	\$20 <a href="#">copay</a> for 34-day supply \$30 <a href="#">copay</a> for 90-day supply	\$20 <a href="#">copay</a> for 34-day supply	
	Non-preferred drugs (Tier 3)	\$30 <a href="#">copay</a> for 34-day supply \$40 <a href="#">copay</a> for 90-day supply	\$30 <a href="#">copay</a> for 34-day supply	
	<a href="#">Specialty drugs</a> (Tier 4)	\$40 <a href="#">copay</a> /prescription	\$40 <a href="#">copay</a> /prescription	
<b>If you have outpatient surgery</b>	Facility fee (ambulatory surgery center, outpatient facility, etc.)	\$50 <a href="#">copay</a> /visit surgery center, outpatient hospital, etc.	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for some services.
	Physician/surgeon fees	Facility <a href="#">copay</a> covers surgical professional fees	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for some services. If surgery is performed in physician's office, the applicable office visit <a href="#">copay</a> applies.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit (30% <a href="#">coinsurance</a> if not an <a href="#">emergency medical condition</a> )	Emergency room <a href="#">copay</a> is waived if you are admitted to the hospital. You may contact the <a href="#">No Surprises Help Desk</a> at 1-800-985-3059.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance for air ambulance</a> ; 10% <a href="#">coinsurance for other types of emergency medical transportation</a>	10% <a href="#">coinsurance</a> for air ambulance; 30% <a href="#">coinsurance</a> for other types of <a href="#">emergency medical transportation</a>	None
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None

**Questions?** For more information about your prescription drug coverage, you can register at [www.caremark.com](http://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)	
<b>If you have a hospital stay</b>	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.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 <u>copay</u> /primary care visit \$10 <u>copay</u> /specialist 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.
<b>If you are pregnant</b>	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. Cost sharing does not apply to preventive services.
	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage of a home health aide as part of an approved treatment program is limited to 40 visits per year. Other limitations apply and <a href="#">preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	\$10 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Coverage is limited to annual max of 50 days of combined rehab services (speech, physical and occupational therapies, cardiac rehab, etc.).
	<a href="#">Habilitation services (ABA therapy only)</a>	100% after \$10 copay/visit	30% coinsurance	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> 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.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. Rental limited to purchase price.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required and some limitations apply.
<b>If your child needs dental care or routine eye care</b>	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 (except for ABA therapy for autism)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Surgical vision correction
- 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.
- 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](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 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](http://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](http://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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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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
<b>The total Peg would pay is</b>	<b>\$350</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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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
<b>The total Joe would pay is</b>	<b>\$920</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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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
<b>The total Mia would pay is</b>	<b>\$340</b>

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

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