



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 online at [www.cigna.com/sp](http://www.cigna.com/sp). 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 <a href="#">deductible</a>?</p>	<p>For <a href="#">in-network providers</a>: \$2,000/individual or \$4,000/family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <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>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-network <a href="#">preventive care</a> &amp; immunizations, office visits, <a href="#">diagnostic test</a>, <a href="#">prescription drugs</a>, generic <a href="#">prescription drugs</a>, home delivery <a href="#">prescription drugs</a>, emergency room visits, <a href="#">urgent care</a> facility visits 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>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>For <a href="#">in-network providers</a> \$5,000/individual or \$10,000/family                      Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>.</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>What is not included in the <a href="#">out-of-pocket limit</a>?</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>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>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>.</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
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 [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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Not covered	None
	<a href="#">Preventive care/ screening/ immunization</a>	No charge/visit** No charge/visit** No charge/screening** No charge/immunizations** No charge/immunizations**  ** <a href="#">Deductible</a> does not apply	Not covered	Coverage birth through age 5 Coverage age 6 and older None Coverage birth through age 5 Coverage age 6 and older 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge/x-ray No charge/blood work** No charge/independent lab** ** <a href="#">Deductible</a> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & 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>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myCigna.com">www.myCigna.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail); \$10 <a href="#">copay</a> /prescription (home delivery) <a href="#">Deductible</a> does not apply	Not covered	Coverage is limited up to a 30-day supply (retail) and a 90-day supply (home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copay</a> /prescription (retail); \$20 <a href="#">copay</a> /prescription (home delivery) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$35 <a href="#">copay</a> /prescription (retail); \$35 <a href="#">copay</a> /prescription (home delivery) <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$150 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	Per visit <a href="#">copay</a> is waived if admitted
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copay</a> /office visit** No charge/all other services ** <a href="#">Deductible</a> does not apply	Not covered	None
	Inpatient services	No charge/admission	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	16 hour maximum per day
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /PCP visit** \$20 <a href="#">copay</a> /Specialist visit** ** <a href="#">Deductible</a> does not apply	Not covered	Coverage is limited to annual max of: 60 days for <a href="#">Rehabilitation services</a> ; 36 days for Cardiac rehab services; 20 days annual max for Chiropractic care services
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> /PCP visit** \$20 <a href="#">copay</a> /Specialist visit** ** <a href="#">Deductible</a> does not apply	Not covered	Coverage is limited to annual max of: 60 days for <a href="#">Rehabilitation services</a>
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Coverage is limited to 100 days annual max.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	None
	<a href="#">Hospice services</a>	No charge/inpatient; No charge/outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## 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](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (20 days)
- Hearing aids (2 (one per ear) devices per 36 months, through age 21)
- See your Vision Plan
- Infertility treatment

### 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](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](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) or the Massachusetts Division of Insurance at 617-521-7794. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: Massachusetts Division of Insurance at (877) 563-4467. 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

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 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.-----

**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](#) \$2,000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,050</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$1,100</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$660
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>

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