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. 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: **$750**/individual or **$1,500**/family	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.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, prescription drugs, generic prescription drugs, home delivery prescription drugs, emergency room visits, urgent care facility visits 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 **$3,000**/individual or **$6,000**/family Combined medical/behavioral and pharmacy out-of-pocket limit.	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.
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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit Deductible does not apply	Not covered	None
	Specialist visit	$45 copay/visit Deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	Not covered	None None None 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 (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $25 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and 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)	$40 copay/prescription (retail 30 days), $100 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $185 copay/prescription (retail & home delivery 90 days) Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit Deductible does not apply	$150 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$75 copay/visit Deductible does not apply	$75 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copay/office visit** 30% coinsurance/all other services **Deductible does not apply	Not covered	None
	Inpatient services	30% coinsurance	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	30% coinsurance	Not covered	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	16 hour maximum per day
	Rehabilitation services	$15 copay/PCP visit** $45 copay/Specialist visit**/for chiropractor **Deductible does not apply 30% coinsurance	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	30% coinsurance	Not covered	Coverage is limited to 180 days annual max.
	Durable medical equipment	30% coinsurance	Not covered	None
	Hospice services	30% coinsurance/inpatient; 30% coinsurance/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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- 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.)

- Chiropractic care

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. 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.

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, 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	**$750**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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:

Cost Sharing	
Deductibles	$750
Copayments	$20
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,980**

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

The plan's overall deductible	**$750**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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:

Cost Sharing	
Deductibles	$130
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,130**

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

The plan's overall deductible	**$750**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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:

Cost Sharing	
Deductibles	$630
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Teal Plan **Ben Ver:** 9 **Plan ID:** 5814918