**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: $3,000/individual or $6,000/family<br>For out-of-network providers: $6,000/individual or $12,000/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, diagnostic test, in-network prescription drugs. | 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: $8,550/individual or $17,100/family<br>For out-of-network providers: $12,000/individual or $24,000/family<br>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?** | Penalties for failure to obtain pre-authorization for services, 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.cigna.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 **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 | $30 copay/visit<br>Deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $60 copay/visit<br>Deductible does not apply | 50% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge<br>Deductible does not apply | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge<br>Deductible does not apply | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |

| 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**<br><br>More information about prescription drug coverage is available at www.cigna.com | Generic drugs (Tier 1) | $20 copay/prescription (retail 30 days), $60 copay/prescription (retail 90 days); $40 copay/prescription (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 a 90-day supply (home delivery) for Specialty drugs.<br>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.<br>For drugs in the Clinical Day Supply program, you may pay less than the noted cost share for certain specialty drugs.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
| | Preferred brand drugs (Tier 2) | $40 copay/prescription (retail 30 days), $120 copay/prescription (retail 90 days); $80 copay/prescription (home delivery 90 days) Deductible does not apply | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $80 copay/prescription (retail 30 days), $240 copay/prescription (retail 90 days); $200 copay/prescription (home delivery 90 days) Deductible does not apply | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | $150 copay/visit | Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share and deductible. |

| 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) | |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network air ambulance services are paid at the in-network cost share and deductible. Services for MH/SA diagnoses will be payable according to Emergency room care benefits. |
| | Urgent care | $50 copay/visit | $50 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 copay/office visit**<br>20% coinsurance/all other services<br>**Deductible does not apply | 50% coinsurance/office visit<br>50% coinsurance/all other services | $500 penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses. |
| | Inpatient services | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses. |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.<br>Cost sharing does not apply for preventive services.<br>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 | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification.<br>16 hour maximum per day |

| 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) | |
| | Rehabilitation services | $30 copay/PCP visit**<br><br>$60 copay/ Specialist visit**<br>**Deductible does not apply | 50% coinsurance/PCP visit<br><br>50% coinsurance/ Specialist visit | Coverage is limited to annual max of: 60 days for Rehabilitation and Cardiac rehab services<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | $30 copay/PCP visit**<br><br>$60 copay/ Specialist visit**<br>**Deductible does not apply | 50% coinsurance/PCP visit<br><br>50% coinsurance/ Specialist visit | Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification.<br>Coverage is limited to 160 days annual max. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | $500 penalty for no out-of-network precertification. |
| | Hospice services | 20% coinsurance/inpatient services<br>20% coinsurance/outpatient services | 50% coinsurance/inpatient services<br>50% coinsurance/outpatient services | $500 penalty for no out-of-network precertification. |
| **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.) | | |
|---|---|---|
| • Bariatric surgery<br>• Cosmetic surgery<br>• Dental care (Adult)<br>• Dental care (Children) | • Eye care (Children)<br>• Infertility treatment<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Private-duty nursing<br>• Routine eye care (Adult)<br>• Routine foot care<br>• Weight loss programs |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Acupuncture | • Chiropractic care | • Hearing aids (1 device per ear per 36 months) |

### 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: Cigna at 1-800-Cigna24, 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 on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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: New Hampshire Department of Insurance at (800) 852-3416.

### 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 | $3,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $3,000 |
| Copayments | $40 |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | $4,660 |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $0 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | $1,040 |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $1,780 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $2,280 |

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

**Plan Name:** OAP1 Silver Plan **Ben Ver:** 36 **Plan ID:** 39684180

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# Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

**Cigna Healthcare:**

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator
P.O. Box 188016, Chattanooga, TN 37422,
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, DC 20201
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at
**https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

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## Proficiency of Language Assistance Services

**English –** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish –** ATENCIÓN: Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese –** 注意：如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

**Vietnamese –** XIN LƯU Ý: Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean –** 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십 시오.

**Tagalog –** PAUNAWA: Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian –** ВНИМАНИЕ: Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic -** تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711 :TTY) 1-800-244-6224

**French Creole –** ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòma ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French –** ATTENTION : Si vows parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese –** ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish –** UWAGA: Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese –** 注意: 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

**Italian –** ATTENZIONE: Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: comporre il 711) o parla con il tuo fornitore.

**German –** Achtung: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) -** همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید :TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره1-800-244-6224.ارائه‌دهنده خود صحبت کنید