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, call **1-855-OSCAR-55** or visit **https://www.hioscar.com/forms/2021/ga**. 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 **www.healthcare.gov/sbc-glossary/** or call **1-855-OSCAR-55** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	$0 individual / $0 family for **in-network** and $5,000 individual / $10,000 family for out-of-network	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there services covered before you meet your **deductible**?	Yes. **Preventive care** and pre- and post-natal care.	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**?	$8,000 individual / $16,000 family for **in-network** and $20,000 individual / $40,000 family for out-of-network	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 healthcare this **plan** does not 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.hioscar.com** or call **1-855-OSCAR-55** 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
		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	$50 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	Telemedicine Visits from designated Telemedicine **Providers** are covered in full; **deductible** does not apply.
	Specialist visit	$80 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	——————none——————
	Preventive care/ **screening**/ immunization	No charge	30% **coinsurance** subject to **deductible**	Out-of-network **deductible** waived for children through age 5. If you receive non-preventive services during a preventive visit, the applicable cost share will apply to those non-preventive services.
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge (x-ray/lab work)	30% **coinsurance** subject to **deductible**	**Preauthorization** may be required.
	Imaging (CT/PET scans, MRIs)	$550 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.hioscar.com/search/GA/drugs?year=2021**	Generic drugs (Tier 1)	$3 **copay**/prescription **Deductible** does not apply (retail, Tier 1A), $15 **copay**/prescription **Deductible** does not apply (retail, Tier 1B)	$3 **copay**/prescription **Deductible** does not apply (retail, Tier 1A), $15 **copay**/prescription **Deductible** does not apply (retail, Tier 1B)	**Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied. Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 3x the retail **cost-sharing** amount.
	Preferred brand drugs (Tier 2)	$40 **copay**/prescription **Deductible** does not apply (retail)	$40 **copay**/prescription **Deductible** does not apply (retail)	
	Non-preferred brand drugs (Tier 3)	$80 **copay**/prescription **Deductible** does not apply (retail)	$80 **copay**/prescription **Deductible** does not apply (retail)	
	Specialty drugs (Tier 4)	25% **coinsurance** **Deductible** does not apply (Tier 4A - Accredo), 45% **coinsurance** **Deductible** does not apply (Tier 4B - All Other Pharmacies)	45% **coinsurance** **Deductible** does not apply (Tier 4B - All Other Pharmacies)	Up to $500 per script for Tier 4A - Accredo. **Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** may be required.
	Physician/surgeon fees	No charge	30% **coinsurance** subject to **deductible**	**Preauthorization** may be required.
If you need immediate medical attention	**Emergency room care**	$600 **copay**/visit **Deductible** does not apply (ER Facility Fee), No charge (ER Physician Fee)	$600 **copay**/visit **Deductible** does not apply (ER Facility Fee), No charge (ER Physician Fee)	Cost-share waived if admitted. Out of **network** Emergency Room services are covered if the services are for an emergency condition.
	Emergency medical transportation	$600 **copay**/visit **Deductible** does not apply	$600 **copay**/visit **Deductible** does not apply	**Preauthorization** is required for non-emergency transportation. If you don't get **preauthorization**, payment for care may be denied.
	Urgent care	$100 **copay**/visit **Deductible** does not apply	$100 **copay**/visit **Deductible** does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.
	Physician/surgeon fees	No charge	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 **copay**/visit **Deductible** does not apply (office visit), 0% **coinsurance**/visit **Deductible** does not apply (for other outpatient services)	30% **coinsurance** subject to **deductible**	——————none——————
	Inpatient services	$300 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office Visits	No charge	30% **coinsurance** subject to **deductible**	Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. **Cost-sharing** does not apply for **preventive services**.
	Childbirth/delivery professional services	No charge	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Childbirth/delivery facility services	$300 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section.
If you need help recovering or have other special health needs	**Home health care**	$80 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 120 visits per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$80 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.)
	Habilitation services	$80 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	**Skilled nursing care**	$300 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. 60 days per benefit period.
	Durable medical equipment	No charge	30% **coinsurance** subject to **deductible**	**Preauthorization** may be required.
	Hospice services	$300 **copay**/visit **Deductible** does not apply	30% **coinsurance** subject to **deductible**	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. Inpatient hospice care subject to inpatient hospital cost share.
If your child needs dental or eye care	Children's eye exam	No charge	30% **coinsurance** subject to **deductible**	One (1) exam per benefit period. One (1) exam per benefit period for children up to age 19.
	Children's glasses	30% **coinsurance** **Deductible** does not apply	30% **coinsurance** subject to **deductible**	One (1) prescribed lenses and frames per Benefit Period for children up to age 19. $150 allowance for Lenses and Frames, or Contact Lenses.
	Children's dental check-up	No charge	30% **coinsurance** subject to **deductible**	One (1) preventive visit per 6 months.

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**.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Chiropractic care
- Hearing aids
- Weight loss programs (limits apply)

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 more information about your rights, this notice, or assistance, contact: 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.

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 **1-855-OSCAR-55**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-OSCAR-55**.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-855-OSCAR-55**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-855-OSCAR-55**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	$0
Specialist copay	$80
Hospital (facility) copay	$300
Other copay	$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay:	**$350**

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

The plan's overall deductible	$0
Specialist copay	$80
Hospital (facility) copay	$200
Other copay	$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay:	**$1,520**

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

The plan's overall deductible	$0
Specialist copay	$80
Hospital (facility) copay	$200
Other copay	$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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay:	**$1,400**

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

Notice of Non-Discrimination:

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities 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 services at all times to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016 Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card.

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación.

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên.

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card.

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана.

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.

Armenian(Eastern) – ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Ձեզ հասանելի են անվճար լեզվական օգնության ծառայություններ: Cigna-ի ընթացիկ հաճախորդների համար, զանգահարեք Ձեր ճանաչողական քարտի դարձակողմում գտնվող համարով:

Punjabi (India), – ਧਿਆਨ ਦੋ: ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ, ਉਪਲਬਧ ਹਨ. ਮੌਜੂਦਾ Cigna ਗਾਹਕਾਂ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ

Khmer – ចំណាប់អារម្មណ៍៖ សេវាជំនួយខាងភាសាឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សំរាប់អតិថិជន Cigna បច្ចុប្បន្ន ហៅលេខនៅខាងខ្នង នៃប័ណ្ណ ID របស់អ្នក។

Hmong– LUS CEEV: Muaj kev pab txhais lus pub dawb rau koj. Rau cov neeg qhuas tam sim no rau ntawm Cigna, hu rau tus nab npawb xov tooj nyob sab tom qab ntawm koj daim npav ID.

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。