Cigna+Oscar Open Access Plus Gold $0 Schedule of Benefits

Services and supplies may be provided by either an In-Network or Out-of-Network Provider. However, some services require preauthorization to be covered. Out-of-Network reimbursement is based on the Allowed Amount. Your certificate has detailed information about how the Allowed Amount is calculated. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this Plan, call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level. This schedule is intended to help you compare covered benefits and is a summary only. The Policy and Certificate and Disclosure Form should be consulted for a detailed description of covered benefits and limitations.

Deductible

This is the amount of covered charges that a Member must pay before this Policy and Certificate and Disclosure Form pays any benefits for such charges. Deductible does not include Coinsurance, Copayments, any amounts above the Allowed Amount and Non-Covered Charges. Deductibles do not cross-accumulate between In-Network and Out-of-Network.

Maximum Out of Pocket

This is the annual maximum dollar amount that a Member must pay as Copayment, Deductible, and Coinsurance for all covered services and supplies in a Plan Year. All amounts paid as a Copayment, Deductible, and Coinsurance shall count toward the Maximum Out of Pocket. Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible, or Coinsurance for In-Network covered services and supplies for the remainder of the Plan Year. Non-Compliance penalties and provider charges in excess of the Allowed Amount do not contribute to the Maximum Out-of-Pocket amount. Out-of-Pocket Maximums do not cross-accumulate between In-Network and Out-of-Network.

Copayment

This is a specified dollar amount a Member must pay for specified Covered Charges.

Coinsurance

This is the percentage of a Covered Charge that must be paid by a Member.

In-Network Deductible	
Individual	$0.00
Family	$0.00

In-Network Out-of-Pocket Maximum	
Individual	$8,000.00
Family	$16,000.00

Out-of-Network Deductible	
Individual	$5,000.00
Family	$10,000.00

Out-of-Network Out-of-Pocket Maximum	
Individual	$20,000.00
Family	$40,000.00

Medical Professional Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits	$50.00 copayment not subject to deductible	30% coinsurance after deductible	
Specialist Office Visits	$80.00 copayment not subject to deductible	30% coinsurance after deductible	
Virtual Care Visits	$0 copayment not subject to deductible	30% coinsurance after deductible	Telemedicine from designated telemedicine providers are covered in full; deductible does not apply.
Preventive Care Visits	Covered in full	30% coinsurance after 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.
Laboratory Procedures	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
X-rays and Diagnostic Imaging	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Advanced Imaging (MRIs and CT/PET scans)	$550.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization may be required.
Outpatient Rehabilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$80.00 copayment not subject to deductible	30% coinsurance after deductible	40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.)
Outpatient Habilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$80.00 copayment not subject to deductible	30% coinsurance after deductible	40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.)
Chiropractic Services	$80.00 copayment not subject to deductible	30% coinsurance after deductible	40 visits per benefit period.

Emergency/Urgent and Ambulance Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Room Facility Fee	$600.00 copayment not subject to deductible	$600.00 copayment not subject to deductible	Cost-share waived if admitted. Out of network Emergency Room services are covered if the services are for an emergency condition.
Emergency Room Physician Fee	Covered in full	Covered in full	Cost-share waived if admitted. Out of network Emergency Room services are covered if the services are for an emergency condition.
Urgent Care Center	$100.00 copayment not subject to deductible	$100.00 copayment not subject to deductible	
Emergency Transportation/Ambulance	$600.00 copayment not subject to deductible	$600.00 copayment not subject to deductible	Preauthorization is required for non-emergency transportation. If you don't get preauthorization, payment for care may be denied.
Medical Outpatient Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Outpatient Hospital Facility Fee	$200.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization may be required.
Outpatient Physician/Surgeon Fee	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Medical Inpatient Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital Facility Fee	$300.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
Inpatient Physician/Surgeon Fee	Covered in full	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
Skilled Nursing Facility Fee	$300.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. 60 days per benefit period.

Maternity and Newborn Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prenatal and Postnatal Care recommended by the USPSTF and HRSA	Covered in full	30% coinsurance after deductible	Preventive services are recommended by the U.S. Preventive Care Task Force (USPSTF) and the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.
Laboratory Services for Prenatal and Postnatal Care	Covered in full	30% coinsurance after deductible	Depending on the type of services (such as Primary Care Office Visits, Specialist Office Visits, Diagnostic Imaging Services, etc.), the applicable cost-sharing will apply.
Inpatient Hospital and Birthing Center	$300.00 copayment not subject to deductible	30% coinsurance after 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.
Physician and Midwife Services for Delivery	Covered in full	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied.
Breast Pumps	Covered in full	30% coinsurance after deductible	One (1) Breast Pump per Benefit Period.
Anesthesia Services (all settings)	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Outpatient Anesthesia	Covered in full	30% coinsurance after deductible	
Inpatient Anesthesia	Covered in full	30% coinsurance after deductible	

Additional Services, Equipment and Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Durable Medical Equipment, Prosthetics and Orthotics	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Hearing Aids	Covered in full	30% coinsurance after deductible	Maximum of 1 hearing aid per ear, per benefit period.
Home Health Care Services	$80.00 copayment not subject to deductible	30% coinsurance after 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.)
Hospice Services	$300.00 copayment not subject to deductible	30% coinsurance after 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.
Chemotherapy	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Diabetic Equipment	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Diabetic Supplies	$40.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization may be required.
Diabetic Education	$50.00 copayment not subject to deductible	30% coinsurance after deductible	
Nutritional Counseling	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Performed in a PCP office	$50.00 copayment not subject to deductible	30% coinsurance after deductible	4 visits/year; Nutritional counseling for the treatment of obesity, which includes morbid obesity, limited to 4 visits/year. (Limits not applicable to mental health and substance use disorder conditions.)
Performed in a Specialist office	$80.00 copayment not subject to deductible	30% coinsurance after deductible	4 visits/year; Nutritional counseling for the treatment of obesity, which includes morbid obesity, limited to 4 visits/year. (Limits not applicable to mental health and substance use disorder conditions.)

Mental Health Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Services	$300.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
Outpatient Mental Health Office Visits	$50.00 copayment not subject to deductible	30% coinsurance after deductible	
Outpatient Mental Health Services - Non-Office	Covered in full	30% coinsurance after deductible	Preauthorization may be required.
Chemical Dependency/Substance Use Disorder Services	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Chemical/Substance Use Disorders	$300.00 copayment not subject to deductible	30% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
Outpatient Chemical/Substance Use Disorders Office Visits	$50.00 copayment not subject to deductible	30% coinsurance after deductible	
Outpatient Chemical/Substance Use Disorders Services - Non Office	Covered in full	30% coinsurance after deductible	Preauthorization may be required.

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy (30-day supply)			Your cost for a covered prescription drug will be the lower of the pharmacy's retail price or the applicable cost-sharing amount for the drug. The amount you pay will be applied to your plan deductible and out-of-pocket maximum limit. Preauthorization/step-therapy may be required.
Tier 1A - Preferred Generic Drugs	$3.00 copayment not subject to deductible	$3.00 copayment not subject to deductible	
Tier 1B - Non-Preferred Generic Drugs	$15.00 copayment not subject to deductible	$15.00 copayment not subject to deductible	
Tier 2 - Preferred Brand Name	$40.00 copayment not subject to deductible	$40.00 copayment not subject to deductible	
Tier 3 - Non-preferred Brand Name	$80.00 copayment not subject to deductible	$80.00 copayment not subject to deductible	
Tier 4a - Specialty Drugs - Accredo (Limited to a 30-day supply)	25% coinsurance not subject to deductible	25% coinsurance not subject to deductible	Up to $500 per script.
Tier 4b - Specialty Drugs - All Other Pharmacies (Limited to a 30-day supply)	45% coinsurance not subject to deductible	45% coinsurance not subject to deductible	
90-day supply for Maintenance Drugs			Your cost for a covered prescription drug will be the lower of the pharmacy's retail price or the applicable cost-sharing amount for the drug. The amount you pay will be applied to your plan deductible and out-of-pocket maximum limit. Preauthorization/step-therapy may be required.
Tier 1A - Preferred Generic Drugs	$9.00 copayment not subject to deductible	$9.00 copayment not subject to deductible	
Tier 1B - Non-Preferred Generic Drugs	$45.00 copayment not subject to deductible	$45.00 copayment not subject to deductible	
Tier 2 - Preferred Brand Name	$120.00 copayment not subject to deductible	$120.00 copayment not subject to deductible	
Tier 3 - Non-preferred Brand Name	$240.00 copayment not subject to deductible	$240.00 copayment not subject to deductible	

Mail Order Pharmacy - 90-day supply (except for Tier 4)			Your cost for a covered prescription drug will be the lower of the pharmacy's retail price or the applicable cost-sharing amount for the drug. The amount you pay will be applied to your plan deductible and out-of-pocket maximum limit. Preauthorization/step-therapy may be required.
Tier 1A - Preferred Generic Drugs	$9.00 copayment not subject to deductible	$9.00 copayment not subject to deductible	
Tier 1B - Non-Preferred Generic Drugs	$45.00 copayment not subject to deductible	$45.00 copayment not subject to deductible	
Tier 2 - Preferred Brand Name	$120.00 copayment not subject to deductible	$120.00 copayment not subject to deductible	
Tier 3 - Non-preferred Brand Name	$240.00 copayment not subject to deductible	$240.00 copayment not subject to deductible	
Tier 4a - Specialty Drugs - Accredo (Limited to a 30-day supply)	25% coinsurance not subject to deductible	25% coinsurance not subject to deductible	Up to $500 per script.
Tier 4b - Specialty Drugs - All Other Pharmacies (Limited to a 30-day supply)	45% coinsurance not subject to deductible	45% coinsurance not subject to deductible	

Pediatric Dental and Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			Preauthorization required for orthodontics and major services. The cost-sharing responsibilities listed below for Pediatric Dental benefits apply to services rendered by Participating Providers.
Diagnostic and Preventive Dental Care	Covered in full	30% coinsurance after deductible	One (1) visit per 6 months.
Basic Services	20% coinsurance not subject to deductible	30% coinsurance after deductible	
Major Services	30% coinsurance not subject to deductible	30% coinsurance after deductible	
Orthodontics	30% coinsurance not subject to deductible	30% coinsurance after deductible	
Pediatric Vision Care			
Vision Exams	Covered in full	30% coinsurance after deductible	One (1) exam per benefit period for children up to age 19.
Lenses and Frames	30% coinsurance not subject to deductible	30% coinsurance after 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, not subject to deductible.
Contact Lenses	30% coinsurance not subject to deductible	30% coinsurance after deductible	Only in lieu of glasses for children up to age 19. $150 allowance for Lenses and Frames, or Contact Lenses, not subject to the deductible.

Eligible American Indians are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Policy and Certificate and Disclosure Form, You will be responsible for the full cost of the services.

*Emergency Medical Conditions and Urgent Care Coverage are covered by Us. Members are responsible for their respective cost share only (copay, coinsurance, deductible) when services are received in-network. There could be additional costs for Out-of-Network Emergency Care. Your certificate has detailed information about how the Out-of-Network Emergency Care reimbursement is calculated.

You may contact the Georgia Office of Insurance and Safety Fire Commissioner to obtain information on companies, coverage, rights or complaints at:

800-656-2298

You may write the Georgia Office of Insurance and Safety Fire Commissioner at:

2 Martin Luther King Jr. Dr.

Atlanta, GA 30334

Web: http://www.oci.ga.gov

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.

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou.

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité.

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação.

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej.

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

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione.

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an.

Persian (Farsi) –توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید.