



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/2022/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 ?	\$3,500 individual / \$7,000 family for in-network and \$10,000 individual / \$20,000 family for out-of-network	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 , pre-and post-natal care, PCP/ Specialist visits, Ind Lab, Emergency transportation, outpatient mental health/substance use disorders office visits, ER visits, urgent care , home health, T1-T4 drugs, Pediatric Vision, and Pediatric Dental.	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 ?	\$8,550 individual / \$17,100 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	\$30 copayment /visit Deductible does not apply	30% coinsurance subject to deductible	Cost share applies to both in-person and virtual visits. Virtual Urgent Care visits from Oscar-designated Telemedicine providers are covered in full; deductible does not apply.
	Specialist visit	\$80 copayment /visit Deductible does not apply	30% coinsurance subject to deductible	Cost share applies to both in-person and virtual visits. Virtual Urgent Care visits from Oscar-designated Telemedicine providers are covered in full; deductible does not apply.
	Preventive care/ screening/ immunization	No charge	30% coinsurance subject to deductible	If you receive non-preventive services during a preventive visit, the applicable cost share will apply to those non-preventive services. Out-of-network deductible waived for children through age 5.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copayment /visit subject to deductible (x-ray), No charge (Independent labs), \$0 copayment /visit subject to deductible (All other OP labs)	30% coinsurance subject to deductible	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	\$0 copayment /visit subject to deductible	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=2022	Generic drugs (Tier 1)	\$3 copayment /prescription Deductible does not apply (retail, Tier 1A), \$15 copayment /prescription Deductible does not apply (retail, Tier 1B), \$7.50 copayment /prescription Deductible does not apply (mail order, Tier 1A), \$37.50 copayment /prescription Deductible does not apply (mail order, Tier 1B)	\$3 copayment /prescription Deductible does not apply (retail, Tier 1A), \$15 copayment /prescription Deductible does not apply (retail, Tier 1B), \$7.50 copayment /prescription Deductible does not apply (mail order, Tier 1A), \$37.50 copayment /prescription Deductible does not apply (mail order, Tier 1B)	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail cost-sharing amount.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.hioscar.com/search/GA/drugs?year=2022	Preferred brand drugs (Tier 2)	\$50 copayment /prescription Deductible does not apply (retail), \$125 copayment /prescription Deductible does not apply (mail order)	\$50 copayment /prescription Deductible does not apply (retail), \$125 copayment /prescription Deductible does not apply (mail order)	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	\$140 copayment /prescription Deductible does not apply (retail), \$350 copayment /prescription Deductible does not apply (mail order)	\$140 copayment /prescription Deductible does not apply (retail), \$350 copayment /prescription Deductible does not apply (mail order)	Retail is limited to a 30-day supply. Mail Order is limited to a 90-day supply and is subject to 2.5x the retail cost-sharing amount.
	Specialty drugs (Tier 4)	25% coinsurance Deductible does not apply (Tier 4A - Accredo), 45% coinsurance Deductible does not apply (Tier 4B - All Other Pharmacies)	25% coinsurance Deductible does not apply (Tier 4A - Accredo), 45% coinsurance Deductible does not apply (Tier 4B - All Other Pharmacies)	Up to \$500 per script for Accredo. Limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 copayment /visit subject to deductible	30% coinsurance subject to deductible	Preauthorization may be required.
	Physician/surgeon fees	\$0 copayment /visit subject to deductible	30% coinsurance subject to deductible	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	\$500 copayment /visit Deductible does not apply (ER Facility Fee), No charge (ER Physician Fee)	\$500 copayment /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	\$500 copayment /visit Deductible does not apply	\$500 copayment /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 copayment /visit Deductible does not apply	\$100 copayment /visit Deductible does not apply	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copayment /day subject to deductible	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.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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 a hospital stay	Physician/surgeon fees	\$0 <u>copayment</u> /visit subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , payment for care may be denied. However, <u>preauthorization</u> is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> /visit <u>Deductible</u> does not apply (office visit), \$0 <u>copayment</u> /visit subject to <u>deductible</u> (for other outpatient services)	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
	Inpatient services	\$0 <u>copayment</u> /day subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , payment for care may be denied. However, <u>preauthorization</u> is not required for emergency admissions.
If you are pregnant	Office Visits	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Cost-sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	\$0 <u>copayment</u> /visit subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required.
	Childbirth/delivery facility services	\$0 <u>copayment</u> /day subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	Covers 48-hour hospital stay for uncomplicated vaginal birth and 96-hour hospital stay for uncomplicated caesarean section. <u>Preauthorization</u> is required.
If you need help recovering or have other special health needs	<u>Home health care</u>	\$80 <u>copayment</u> /visit <u>Deductible</u> does not apply	30% <u>coinsurance</u> subject to <u>deductible</u>	120 visits per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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	<u>Rehabilitation services</u>	\$0 <u>copayment</u> /visit subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.
	<u>Habilitation services</u>	\$0 <u>copayment</u> /visit subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	40 visits combined per benefit period. (The limit is not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.
	<u>Skilled nursing care</u>	\$0 <u>copayment</u> /day subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	60 days per Benefit Period. <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	\$0 <u>copayment</u> / subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
	<u>Hospice services</u>	\$0 <u>copayment</u> /day subject to <u>deductible</u>	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , payment for care may be denied.
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	One (1) exam per benefit period for children up to age 19.
	Children's glasses	30% <u>coinsurance</u> <u>Deductible</u> does not apply	50% <u>coinsurance</u> subject to <u>deductible</u>	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% <u>coinsurance</u> subject to <u>deductible</u>	One (1) preventive visit per 6 months.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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
- 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
- Hearing aids

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, kwijigo holne' **1-855-OSCAR-55**.

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

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2022/ga>.

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	\$3,500
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$0
■ Other copayment	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,500

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$3,500
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$0
■ Other copayment	\$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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$3,500
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$0
■ Other copayment	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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 연락해주시요.

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 sè vis è d nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dè yè 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.