



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/2023/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 <u>in-network</u> and \$5,000 individual / \$10,000 family for <u>out-of-network</u>	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. All <u>in-network</u> services	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$8,950 individual / \$17,900 family for <u>in-network</u> and \$20,000 individual / \$40,000 family for <u>out-of-network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, and healthcare this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.hioscar.com/search/?networkId=025&year=2023 or call 1-855-OSCAR-55 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>copayment</u> /visit	30% <u>coinsurance</u> subject to <u>deductible</u>	Cost share applies to both in-person and virtual visits. Virtual <u>Urgent Care</u> visits from Oscar-designated <u>Telemedicine Providers</u> are covered in full; <u>Deductible</u> does not apply
	<u>Specialist</u> visit	\$80 <u>copayment</u> /visit	30% <u>coinsurance</u> subject to <u>deductible</u>	Cost share applies to both in-person and virtual visits. Virtual <u>Urgent Care</u> visits from Oscar-designated <u>Telemedicine Providers</u> are covered in full; <u>Deductible</u> does not apply
	<u>Preventive</u> care/ <u>screening</u> / immunization	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	If you receive non-preventive services during a <u>preventive</u> visit, the applicable cost share will apply to those non-preventive services. <u>Out-of-network deductible</u> waived for children through age 5.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge (x-ray/Independent labs/All other OP labs)	30% <u>coinsurance</u> subject to <u>deductible</u> (x-ray/Independent labs/All other OP labs)	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	\$750 <u>copayment</u> /scan (OV/Independent), \$1,250 <u>copayment</u> /scan (All other outpatient)	30% <u>coinsurance</u> subject to <u>deductible</u> (OV/Independent/All other outpatient)	<u>Preauthorization</u> may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hioscar.com/search-documents/drug-formularies/	Generic drugs (Tier 1)	\$3 <u>copayment</u> /prescription (retail, Tier 1A), \$15 <u>copayment</u> /prescription (retail, Tier 1B), \$7.50 <u>copayment</u> /prescription (mail order, Tier 1A) \$37.50 <u>copayment</u> /prescription (mail order, Tier 1B)	\$3 <u>copayment</u> /prescription (retail, Tier 1A), \$15 <u>copayment</u> /prescription (retail, Tier 1B), \$7.50 <u>copayment</u> /prescription (mail order, Tier 1A) \$37.50 <u>copayment</u> /prescription (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 retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2023/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 <u>prescription drug coverage</u> is available at www.hioscar.com/search-documents/drug-formularies/	Preferred brand drugs (Tier 2)	\$50 <u>copayment</u> /prescription (retail), \$125 <u>copayment</u> /prescription (mail order)	\$50 <u>copayment</u> /prescription (retail), \$125 <u>copayment</u> /prescription (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 retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required.
	Non-preferred brand drugs (Tier 3)	\$125 <u>copayment</u> /prescription (retail), \$312.50 <u>copayment</u> /prescription (mail order)	\$125 <u>copayment</u> /prescription (retail), \$312.50 <u>copayment</u> /prescription (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 retail <u>cost-sharing</u> amount. <u>Preauthorization</u> /step therapy may be required.
	<u>Specialty drugs</u> (Tier 4)	25% <u>coinsurance</u> (Tier 4A - Accredo), 40% <u>coinsurance</u> (Tier 4B - All Other Pharmacies)	25% <u>coinsurance</u> (Tier 4A - Accredo), 40% <u>coinsurance</u> (Tier 4B - All Other Pharmacies)	Limited to a 30-day supply. Up to \$500 per script (Tier 4A - Accredo). <u>Preauthorization</u> /step therapy may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,000 <u>copayment</u> /visit (surgical and non-surgical services)	30% <u>coinsurance</u> subject to <u>deductible</u> (surgical and non-surgical services)	<u>Preauthorization</u> may be required.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$900 <u>copayment</u> /visit (ER Facility Fee), No charge (ER Physician Fee)	\$900 <u>copayment</u> /visit (ER Facility Fee), No charge (ER Physician Fee)	The first Ambulance trip and Emergency Room visit each Benefit Period is \$600 <u>copay</u> . Each additional trip or visit is \$900 <u>copay</u> . Cost share waived if admitted. You pay the same level as <u>in-network</u> if it is an emergency as defined in your <u>plan</u> , otherwise you pay 100%.
	<u>Emergency medical transportation</u>	\$900 <u>copayment</u> /visit	\$900 <u>copayment</u> /visit	The first Ambulance trip and Emergency Room visit each Benefit Period is \$600 <u>copay</u> . Each additional trip or visit is \$900 <u>copay</u> . <u>Preauthorization</u> is required for non-emergency transportation.

*For more information about limitations, exceptions, and prior authorization, see the plan or policy document at <https://www.hioscar.com/forms/2023/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 immediate medical attention	Urgent care	\$100 <u>copayment</u> /visit	\$100 <u>copayment</u> /visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <u>copayment</u> /day	30% <u>coinsurance</u> subject to <u>deductible</u>	The \$1,000 per day <u>copay</u> applies up to 3 days of an <u>in-network</u> admission. <u>Preauthorization</u> is required. However, <u>Preauthorization</u> is not required for emergency admissions.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required. However, <u>preauthorization</u> is not required for emergency admissions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <u>copayment</u> /visit (office visit), No Charge (for other outpatient services)	30% <u>coinsurance</u> subject to <u>deductible</u> (office visit/other outpatient services)	<u>Preauthorization</u> may be required for Other Outpatient Services. <u>Preauthorization</u> is not required for Outpatient Office visits.
	Inpatient services	\$1,000 <u>copayment</u> /day	30% <u>coinsurance</u> subject to <u>deductible</u>	The \$1,000 per day <u>copay</u> applies up to 3 days of an <u>in-network</u> admission. <u>Preauthorization</u> is required. 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	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required.
	Childbirth/delivery facility services	\$1,000 <u>copayment</u> /day	30% <u>coinsurance</u> subject to <u>deductible</u>	The \$1,000 per day <u>copay</u> applies up to 3 days of an <u>in-network</u> admission. Covers 48- hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated cesarean section. <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/2023/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>Home health care</u>	\$80 <u>copayment</u> /visit	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.
	<u>Rehabilitation services</u>	\$80 <u>copayment</u> /visit	30% <u>coinsurance</u> subject to <u>deductible</u>	40 visits per Benefit Period for all therapy types combined. (Limits not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.
	<u>Habilitation services</u>	\$80 <u>copayment</u> /visit	30% <u>coinsurance</u> subject to <u>deductible</u>	40 visits per Benefit Period for all therapy types combined. (Limits not applicable to mental health and substance use disorder conditions.) <u>Preauthorization</u> is required.
	<u>Skilled nursing care</u>	\$1,000 <u>copayment</u> /day	30% <u>coinsurance</u> subject to <u>deductible</u>	The \$1,000 per day <u>copay</u> applies up to 3 days of an <u>in-network</u> admission. 60 days per Benefit Period. <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> may be required.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u> subject to <u>deductible</u>	<u>Preauthorization</u> is required.
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>	30% <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	No charge	One (1) <u>preventive</u> 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/2023/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 \(3272\)](tel:1-866-444-EBSA) 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](tel: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 \(3272\)](tel:1-866-444-EBSA) 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](tel:1-855-OSCAR-55). Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-855-OSCAR-55](tel: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](tel:1-855-OSCAR-55). Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' [1-855-OSCAR-55](tel:1-855-OSCAR-55).

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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$80
■ <u>Hospital (facility) copayment</u>	\$1,000
■ Other <u>copayment</u>	\$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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,000

Managing Joe's Type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$80
■ <u>Hospital (facility) copayment</u>	\$1,000
■ Other <u>copayment</u>	\$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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,600

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$80
■ <u>Hospital (facility) copayment</u>	\$1,000
■ Other <u>copayment</u>	\$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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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 연락해주시오.

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.