Coverage Period: 07/01/2017 - 12/31/2017

Coverage for: Individual/Individual + Family | Plan Type: OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at <a href="https://www.cigna.com/sp">www.cigna.com/sp</a>. 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 <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: \$1,500/individual or \$3,000/family For out-of-network providers: \$4,500/individual or \$9,000/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care & immunizations, office visits, generic prescription drugs, emergency room visits, urgent care facility visits are covered before you meet your deductible.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes, \$200/individual or \$400/family for in-network prescription drugs; \$200/individual or \$400/family for out-of-network prescription drugs.  There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For in-network providers \$5,000/individual or \$13,000/family For out-of-network providers \$15,000/individual or \$39,000/family Combined medical/behavioral and pharmacy out-of-pocket limit.	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 out-of-pocket limit?	Penalties for failure to obtain <u>pre-authorization</u> for services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See <a href="https://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24 for a list of <a href="https://mww.mycigna.com">network providers</a> .	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</u> 's <u>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</u> 's 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 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		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit <u>Deductible</u> does not apply	50% coinsurance	None
	Specialist visit	\$50 <u>copay</u> /visit <u>Deductible</u> does not apply	50% coinsurance	None
If you visit a health care provider's office or clinic	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations**  **Deductible does not apply	50% coinsurance/visit 50% coinsurance/screening 50% coinsurance/ immunizations	None None You may have to pay for services that aren't preventive. Ask your provider if
		<u>Deductible</u> does not apply		the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	20% penalty for no precertification.

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Generic drugs (Tier 1)	\$10 copay/prescription (retail 30 days), \$20 copay/prescription (retail & home delivery 90 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 00 day
If you need drugs to treat your illness or condition  More information about	Preferred brand drugs (Tier 2)	\$45 copay/prescription (retail 30 days), \$90 copay/prescription (retail & home delivery 90 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs.  Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
prescription drug coverage is available at www.myCigna.com	Non-preferred brand drugs (Tier 3)	\$65 copay/prescription (retail 30 days), \$130 copay/prescription (retail & home delivery 90 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
	Specialty drugs (Tier 4)	\$100 copay/self-administered injectable prescription (retail & home delivery 30 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	20% penalty for no precertification.
surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	20% penalty for no precertification.
	Emergency room care	\$250 copay/visit Deductible does not apply	\$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$50 <u>copay</u> /visit <u>Deductible</u> does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	20% penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	20% penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	50% coinsurance/office visit 50% coinsurance/all other services	20% penalty if no precert of non- routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% coinsurance	50% coinsurance	20% penalty for no precertification.

Common		What You Will Pay		Limitations Fuggetions 9 Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Office visits	20% coinsurance	50% coinsurance	Primary Care or Specialist benefit
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	levels apply for initial visit to confirm pregnancy.
If you are pregnant	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Home health care	20% coinsurance	50% coinsurance	20% penalty for no precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	50% coinsurance	20% penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 36 days per therapy type for Pulmonary rehab and Cardiac rehab services; 60 days per therapy type for Physical, Speech, Occupational and Cognitive therapy services; 60 days annual max for Chiropractic care services.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	50% coinsurance	20% penalty for no precertification. Coverage is limited to 60 days annual max.
	<u>Durable medical equipment</u>	20% coinsurance	50% coinsurance	20% penalty for no precertification.
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/outpatient services	50% coinsurance/inpatient; 50% coinsurance/outpatient services	20% penalty for failure to precertify inpatient hospice services.
If you are also the state of th	Children's eye exam	Not covered	Not covered	None
If your child needs dental	Children's glasses	Not covered	Not covered	None
or eye care	Children's dental check-up	Not covered	Not covered	None

### **Excluded Services & Other Covered Services:**

## Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)

- Eye care (Children)
- Habilitation services
- 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 (60 days)

 Hearing aids (2 (one per ear) devices per 3 Years)

## **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 <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="Marketplace">Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596.

#### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u> or the Tennessee Department of Commerce and Insurance at 1-800-342-4029.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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

## **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts ( <u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and excluded services under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
<ul> <li>Specialist copayment</li> </ul>	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,800

## In this example, Peg would pay:

Cost Sharing		
Deductibles	\$1,500	
Copayments	\$60	
Coinsurance	\$2,200	
What isn't covered		
Limits or exclusions	\$10	
The total Peg would pay is	\$3,770	

# Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
<ul><li>Other coinsurance</li></ul>	20%

#### This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)* 

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400
--------------------	---------

## In this example, Joe would pay:

\$330
\$900
\$0
\$200
\$1,430

## **Mia's Simple Fracture**

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

■ The plan's overall deductible	\$1,500
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)* 

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900

## In this example, Mia would pay:

Cost Sharing	
Deductibles	\$630
Copayments	\$500
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,140

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

Plan Name: Base Plan - OAP Ben Ver: 9 Plan ID: 6454168 HP-POL/HP-APP 9/23/12