**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 www.cigna.com/sp. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: $600/individual or $1,200/family<br>For out-of-network providers: $1,200/individual or $2,400/family | 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 & immunizations, office visits, emergency room visits, urgent care facility visits. | 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?** | For in-network providers: $2,500/individual or $5,000/family<br>For out-of-network providers: $5,000/individual or $10,000/family<br>Combined medical/behavioral and pharmacy out-of-pocket limit | 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?** | Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan 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 www.cigna.com or call 1-855-869-8619 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 |
|---|---|---|---|---|
| | | In-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 | $25 copay/visit<br>Deductible does not apply | 30% coinsurance | None |
| | Specialist visit | $35 copay/visit<br>Deductible does not apply | 30% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge<br>Deductible does not apply | 30% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug | Generic drugs (Tier 1) | Not covered | Not covered | Coverage provided by Express Scripts. |
| | Preferred brand drugs (Tier 2) | Not covered | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Not covered | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| coverage is available at www.express-scripts.com | Specialty drugs (Tier 4) | Not covered | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you need immediate medical attention** | Emergency room care | $125 copay/visit<br>Deductible does not apply | $125 copay/visit<br>Deductible does not apply | Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Out-of-network air ambulance services are paid at the in-network cost share and deductible. |
| | Urgent care | $50 copay/visit<br>Deductible does not apply | $50 copay/visit<br>Deductible does not apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/office visit**<br>10% coinsurance/all other services<br>**Deductible does not apply | First 12 visits per Lifetime<br>10% coinsurance<br>Deductible does not apply<br><br>13th visit and after<br>$25 copay, and plan pays 100%<br>30% coinsurance/all other services | $500 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). |
| | Inpatient services | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| **If you are pregnant** | Office visits | 10% coinsurance | 30% coinsurance | Primary Care or Specialist benefit levels apply for initial visit to confirm |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | pregnancy.<br>Cost sharing does not apply for preventive services.<br>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). |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification.<br>16 hour maximum per day |
| | Rehabilitation services | $25 copay/visit<br>Deductible does not apply | 30% coinsurance/PCP visit<br><br>30% coinsurance/ Specialist visit | $500 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 80 days for Rehabilitation services; 36 days for Cardiac rehab services; 20 days for Chiropractic care services.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |
| | Habilitation services | $25 copay/visit<br>Deductible does not apply | 30% coinsurance/PCP visit<br><br>30% coinsurance/ Specialist visit | $500 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.<br><br>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification.<br>Coverage is limited to 100 days annual max. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | $500 penalty for no out-of-network precertification. |
| | Hospice services | 10% coinsurance/inpatient services<br>10% coinsurance/outpatient services | 30% coinsurance/inpatient services<br>30% coinsurance/outpatient services | $500 penalty for no out-of-network precertification. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | 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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- 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.)**

- Acupuncture (20 days)
- Chiropractic care (20 days)
- Hearing aids (1 device per 36 months)
- Infertility treatment ($15,000 lifetime maximum)

### 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 on how 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: 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 www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: New Hampshire Department of Insurance at (800) 852-3416.

## 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 1-800-244-6224.
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 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 | $600 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $600 |
| Copayments | $30 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Peg would pay is** | $1,860 |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $120 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | $4,720 |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $600 |
| Copayments | $300 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | $950 |

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

**Plan Name:** OAP3 **Ben Ver:** 29 **Plan ID:** 17026663