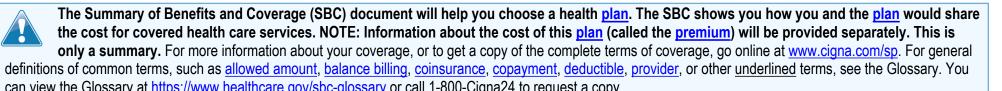
Coverage for: Individual/Individual + Family | Plan Type: OAP



,	The diossaly at <u>https://www.neattreate.gov/sbc-giossaly</u> of call 1-600-Cignaz4 to request a copy.				
Important Questions	Answers	Why This Matters:			
What is the overall <u>deductible</u> ?	For <u>in-network providers</u> : \$2,800/individual - employee only or \$5,600/family maximum (no more than \$2,800 per individual - within a family) For <u>out-of-network providers</u> : \$5,000/individual - employee only or \$10,000/family maximum (no more than \$5,000 per individual - within a family) Combined medical/behavioral and pharmacy <u>deductible</u>	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 <u>deductible</u> ?	Yes. In-network preventive care & immunizations.	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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .			
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.			
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>in-network providers</u> : \$3,750/individual - employee only or \$7,500/family maximum (no more than \$3,750 per individual - within a family) For <u>out-of-network providers</u> : \$10,000/individual - employee only or \$20,000/family maximum (no more than \$10,000 per individual - within a family) Combined medical/behavioral and pharmacy <u>out-of-pocket limit</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 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 <u>network provider</u> ?	Yes. See <u>www.cigna.com</u> or call 1-800-Cigna24 for a list of <u>network providers</u> .	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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common		What Y	ou Will Pay	Limitations Exceptions 2 Other	
Medical Event	Services You May Need	In-Network Provider Out-of-Network Provider (You will pay the least) (You will pay the most)		Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	10% coinsurance/visit	50% coinsurance	None	
	Specialist visit	10% coinsurance/visit	50% coinsurance	None	
If you visit a health care provider's office or clinic	Preventive care/ screening/ immunization	No charge/visit** No charge/ <u>screening</u> ** No charge/immunizations** ** <u>Deductible</u> does not apply	50% <u>coinsurance</u> /visit 50% <u>coinsurance</u> / <u>screening</u> 50% <u>coinsurance</u> / immunizations	None None None You may have to pay for services tha aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	None	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.	

C amman		What You	Limitationa Excentiona 8 Other	
Common Medical Event Services You May Need		In-Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
		(You will pay the least)	(You will pay the most)	
	Generic drugs (Tier 1)	\$10 <u>copay</u> /prescription (retail 30 days), \$25 <u>copay</u> /prescription (retail & home delivery 90 days)	50% <u>coinsurance</u> /prescription (retail and 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 <u>Specialty drugs</u> .
If you need drugs to treat your illness or condition More information about	Preferred brand drugs (Tier 2)	\$35 <u>copay</u> /prescription (retail 30 days), \$88 <u>copay</u> /prescription (retail & home delivery 90 days)	50% <u>coinsurance</u> /prescription (retail and home delivery)	Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
prescription drug coverage is available at www.cigna.com	Non-preferred brand drugs (Tier 3)	\$60 <u>copay</u> /prescription (retail 30 days), \$150 <u>copay</u> /prescription (retail & home delivery 90 days)	50% <u>coinsurance</u> /prescription (retail and home delivery)	For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.
	Specialty drugs (Tier 4)	50% <u>coinsurance</u> but not more than \$150/prescription (retail & home delivery 30 days)	50% <u>coinsurance</u> /prescription (retail and home delivery)	In-network Federally required preventive drugs will be provided at no charge.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.
surgery	Physician/surgeon fees	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.
	Emergency room care	10% coinsurance	10% coinsurance	None
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	50% coinsurance	None
If you have a hospital stay If you need mental health, behavioral health, or	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.
	Outpatient services	10% <u>coinsurance</u> /office visit 10% <u>coinsurance</u> /all other services	50% <u>coinsurance</u> /office visit 50% <u>coinsurance</u> /all other services	50% penalty if no precert of out-of- network non-routine services (i.e., partial hospitalization, etc.).
substance abuse services	Inpatient services	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.

Common		What Yo	Limitationa Exacutiona 8 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	10% coinsurance	50% coinsurance	Primary Care or Specialist benefit	
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	levels apply for initial visit to confirm pregnancy.	
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	

Common		What Yo	What You Will Pay		
Common 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 	
	Home health care	10% <u>coinsurance</u>	50% <u>coinsurance</u>	 50% penalty for no out-of-network precertification. Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.) 	
If you need help recovering or have other special health needs	Rehabilitation services	10% <u>coinsurance</u> /PCP visit 10% <u>coinsurance</u> / <u>Specialist</u> visit	50% <u>coinsurance</u> /PCP visit 50% <u>coinsurance</u> / <u>Specialist</u> visit	 50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation services; 36 days for Cardiac rehab services; 20 days for Chiropractic care services Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. 	
	Habilitation services	10% <u>coinsurance</u> /PCP visit 10% <u>coinsurance</u> / <u>Specialist</u> visit	50% <u>coinsurance</u> /PCP visit 50% <u>coinsurance</u> / <u>Specialist</u> visit	 50% penalty for failure to precertify out-of-network speech therapy services. Services are covered when <u>Medically Necessary</u> to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. 	
	Skilled nursing care	10% <u>coinsurance</u>	50% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.	

Common		What You Will Pay		Limitations Exacutions 2 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		
	Durable medical equipment	10% coinsurance	50% coinsurance	50% penalty for no out-of-network precertification.		
	Hospice services	10% <u>coinsurance</u> /inpatient services 10% <u>coinsurance</u> /outpatient services	50% <u>coinsurance</u> /inpatient services 50% <u>coinsurance</u> /outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.		
lf your child needs dontal	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 	ine eye care (Adult)					
 Cosmetic surgery 	ine foot care					
Dental care (Adult) Non-emergency care when traveling outside the Weig				ht loss programs		
 Dental care (Children) 		U.S.				
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)						
Chiropractic care (20 c	days)	 Hearing aids (\$3,000 maxim Year) 	um per Calendar			

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: Utah Insurance Department at 1-800-439-3805 and 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. For more information about the https://www.dol.gov/ebsa/healthreform. Other coverage through the https://www.dol

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan 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 on how to submit a <u>claim</u>, <u>appeal</u> or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>www.dol.gov/ebsa/healthreform</u> or Utah Insurance Department at 1-800-439-3805.

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

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 <u>excluded services</u> 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 ca hospital delivery)	Managing Jo (a year of routine contro	e ir	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$2,800 90% 10% 10%	 The <u>plan's</u> overa <u>Specialist coins</u> Hospital (facility Other <u>coinsuran</u> 	<u>su</u> /) (
This EXAMPLE event includes service Specialist office visits <i>(prenatal care)</i> Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services	es	This EXAMPLE even Primary care physicia disease education) Diagnostic tests (block	<u>an</u>
Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	d work)	Prescription drugs Durable medical equi	ipr

\$12,700 Total Example C

Total Example Cost

Cost Sharing			
Deductibles	\$2,800		
<u>Copayments</u>	\$0		
Coinsurance	\$900		
What isn't covered			
Limits or exclusions	\$20		
The total Peg would pay is	\$3,720		

Managing Joe's type 2 Dial (a year of routine in-network care o controlled condition)	
The plan's overall deductible	\$2,800
Specialist coinsurance	90%
Hospital (facility) coinsurance	10%
Other coinsurance	10%
This EXAMPLE event includes service	
Primary care physician office visits (incl	luding

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		
\$2,800		
\$300		
\$40		
What isn't covered		
\$20		
\$3,160		

Mia's Simple Fracture(in-network emergency room visit and follow up
care)The plan's overall deductible\$2,800Specialist coinsurance90%Hospital (facility) coinsurance10%Other coinsurance10%

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	\$2,800	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

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

Plan Name: Proposed \$2800 HSA Ben Ver: 22 Plan ID: 14710160 HP-POL/HP-APP 9/23/12

PHOLIMICANNIC PHOLEMAN

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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 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 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 PO 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, DC 20201 1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, Ilame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, Ilame al 1.800.244.6224 (los usuarios de TTY deben Ilamar al 711).

896375b 05/21 © 2021 Cigna.

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. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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。其他客戶請致電 1.800.244.6224 (聽障專線:請撥 711)。

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. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

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. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711). **French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

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. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

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. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

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。その他の方は、1.800.244.6224 (TTY: 711) 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. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

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. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای ممتنزیان فعلی Cigna، لطفاً با شماره ای که در یشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره Cigna، لطفاً با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره گیری کنید).